GUY'S HOSPITAL GAZETTE

NEW SERIES
VOL. 59

1945

Guy's Hospital Gazette.

Guy's Hospital Gazette.

THE WILLS LIBRARY
- 6 JUL 1979
GUY'S HOSPITAL MEDICAL SCHOOL

THE WILLS LIBRARY,
GUY'S HOSPITAL,
LONDON, S.E.1.

GUY'S HOSPITAL GAZETTE

THE WILLS LIBRARY
GUY'S HOSPITAL

VOL. LIX

NEW SERIES

1945

GUY'S HOSPITAL GAZETTE

INDEX

PAGE

A

Appointments .. 58, 70, 110, 158, 182a, 206a, 213
Dental 94
Anderson, R. G. Gayer, In Memoriam 163
Arsenical Poisoning, Chronic, on Superficial Epitheliomata and, (Clinical Lecture), by Dr. L. Forman .. 287
Athletic Club 109, 279

B

Barber, Hugh, The Consultant and Specialist 314
The History of the Signs 196
Clinical Acumen 36
Barber, R. O., A Case of Kummel's Disease with Secondary Pathologies 115
A Case of Dermato-Myositis .. 150
Bell, Miss, appointed Matron, Leicester Royal Infirmary 281
Bensted, J. P. M., resigns Editorship of *Guy's Hospital Gazette* 12
Birdwood, Lieut.-Col. G. T., Obituary 101
Birthday Honours 182a
Births 10, 22, 70, 82, 94, 110, 134a, 158, 170, 182a, 194, 206a, 226, 244, 280a, 296, 308, 322
Bishop, P. M. F. Guy's and the German War 172
Blues, Award of 108, 280a
Boat Club 94, 181, 251
v. Middlesex Hospital 295
Putney Regatta 157
United Hospitals Regatta 169
Boland, E. R., appointed Dean of the Medical School 258
Boxing Club 251
Inter-Hospital Competition .. 33, 57
London University Championships 134
United Hospitals *v.* Oxford University 57, 81
British Dental Students' Association Annual Convention 119
Annual General Meeting 208
Broadcast from Guy's Hospital Chapel 135
by Matron 269
by Guy's Student Singers 297
Brock, R. C., Fractured Ribs and other Chest Injuries (Clinical Lecture) .. 184
Bronchitis, Acute Plastic (with Case Report), by D. F. Johnstone .. 2
Brown, Felix W., Report on York Clinic 129
Burning Question, The, by H. St. H. Vertue 88

C

Cameron, H. C., Retirement of .. 196
A Correction 297
Pains in the Legs in Children (Clinical Lecture) 209
Campbell, Maurice, Digitalis 259
Cancer, The Prevention of, by W. Sampson Handley 72
Cervical Vertebra. First, Exploration of the Region between the Styloid Process and the Transverse Process of the, by Patrick Clarkson .. 100
Changes of Address 10, 21, 34, 46, 70, 82, 94, 110, 122, 146, 158, 170, 182a, 206a, 214, 226, 244, 256, 280a, 296, 308, 322
Changing Clinical Horizons, by "Uncle Harry" 165
Chapman, E., Retirement from Stores Department 215
Chapple, Harold, Death of 59
Obituary 77

PAGE

Chest Injuries, Fractured Ribs and, by R. C. Brock (Clinical Lecture) .. 184
Children, Pains in the Legs in, by H. C. Cameron (Clinical Lecture) 209
Christian Union 252
Clark, Robert, Obituary 258
Clarkson, P. W., appointed Hunterian Lecturer 308
Exploration of the Region between the Styloid Process and the Transverse Process of the First Cervical Vertebra 100
Clinical Acumen, by Hugh Barber .. 36
Discipline, by John A. Ryle 112, 127, 136
Clinical Lectures—
Mr. R. C. Brock, Fractured Ribs and other Chest Injuries 184
Dr. H. C. Cameron, Pains in the Legs in Children 209
Dr. L. Forman, on Superficial Epitheliomata and Chronic Arsenical Poisoning 287
Mr. T. B. Layton, "Dare Quam Accipere" 24
Diseases of the Herd 160
Mr. O. G. Morgan, Thyrotoxicosis in Relation to Ophthalmology .. 148
Dr. A. A. Osman, Factors modifying the Clinical Features and Course of Glomerulo-nephritis 310
Clinical Period 233
To Those Entering, by A. H. Douthwaite 233
Club's Union 112, 238
Consultant and Specialist, by Hugh Barber 314
Correspondence—
E. R. Boland, Equality of Opportunity for All 18
J. Vernon Braithwaite, "A Silent Revolution" 275, 305
H. C. Cameron, Truby King 313
Maurice Campbell, Fair Treatment of Periodicals 44
Bruce Cardew, Letter from Ft.-Lt. H. B. O. Cardew 31
J. J. Conybeare, Closing of W.V.S. Canteen 205
L. Coombe, "A Silent Revolution" 293
F. N. Doubleday, A Message of Thanks 106
Dennis Dennison, Front Surgery Cards 155
A. H. Douthwaite, Post of Clinical Assistant 241
M. Ebbisham, Guy's Hospital Ladies' Association 180
N. L. Eckhoff, Clubs' Union .. 304
C. A. Ensor, Impressive Teaching in Hospital 81
W. E. Evans, Lighting of Gordon Museum 7
Jack Fine, Squash Rackets .. 8
Dennis H. Forsdick, Belsen Concentration Camp 133, 145
Robert C. Greenberg, International Student Service 273
M. S. Griffith, Domestic Workers at Guy's 180
P. C. Grummitt, "Prosthetic Dentistry" 293
R. T. Hinde, Clubs' Union 143
Women Students 66
T. B. Johnston, Ward Hours for Students 193
R. A. Keable-Elliott, Students in Teaching Hospitals 43
K. Y. Khong, Lawn Tennis Club .. 168
F. R. Kilpatrick, Guy's Students' Union 2

PAGE

Correspondence—*continued.*
Gerald W. Korn, Medical Students and International Relationships.. 44
Michael Kugler, Medical Co-Education 67
J. L. Laurenson and J. S. Batchelor "A Silent Revolution" 293
T. B. Layton, A Letter on Garibaldi 152
In Reply to "Uncle Harry" .. 241
J. W. Lewis, Women Students and Medical Schools 106
George R. W. N. Luntz, Women Students in Medicine 67
C. W. Marshall, Refresher Courses.. 181
D. W. Mayman, Women Medical Students 155
G. A. K. Missen, Post-Mortem Instruction 93
G. A. Morrant, Clubs' Union .. 144
Richard Neve, Guy's Hospital Fencing Club 68
Obstetrics in English and Irish Schools 30
C. H. R. O'Mosome, "This Specialism" 169
Evelyn A. Opie, A Tribute to Sister Gale 154
"Perseus."—Praise for the Nursing Services 154
F. Popper, "Prosthetic Dentistry" 274
"Puggly Pani" (S.E.A.C.), Duties of Regimental Medical Officer .. 223
C. Retzius, "Who Was Coude?" .. 306
John Rich, Inter-Hospital Visits .. 266
A. Batty Shaw, Clinical and Medical Instruction 18
E. G. Smith, Lighting of Gordon Museum 29
Florence Taylor, Training for Nurses 168
G. I. Tewfik, Rebuilding at Guy's Hospital 29
Times for Students in Wards .. 192
H. W. Trusted, Harmony of Work in Guy's 193
"Uncle Harry," Diseases of the Herd 212
Malaria at Guy's 253
W. Van T. Hoff, Care of Lawns .. 67
H. St. H. Vertue, "Penncycillin".. 68
Truby King 306
R. D. Walsh, International Student Relationship 32
M. D. Warren, Facilities for Students 222
Impressions from a Municipal Hospital 79
S. H. Wass, The College Catering Company 54
R. G. Watson, Blackmail 67
Clubs' Union 155
M. Weigall, "Guy's and the German War" 213
W. F. D., International Contacts in Medicine 7
George Winston, Minute Books .. 168
Several Signatories, Enlarging the Clubs' Union 106
Post-Mortem Instruction .. 78
Proposed Medical Methods .. 92
Some of the Sisters, Sisters' Comment 205
Cricket 240
Retrospect 254
v. Beckenham 213
v. Bromley Town 156
v. Buccaneers 206
v. Canadian Military H.Q. 224
v. Charing Cross and Royal Dental Hospitals 224
v. Finchley 157
v. Guildford 146
v. Honor Oak 206
v. London Hospital 213
v. Metropolitan Police .. 194, 243
v. Middlesex Hospital 157
v. Old Rutlishians 157
v. Orpington 206
v. Oversea H.Q., R.A.A.F. 146

PAGE

Cricket—*continued.*
v. Public School Wanderers .. 225
v. St. Bart.'s Hospital 194
v. St. Mary's Hospital 206
v. St. Thomas's Hospital 157
Crime, Clinical Aspects of, by W. Norwood East 48, 60

D

Dance, Victory, at Guy's Hospital .. 135
Victory Ball at Vintners' Gall .. 159
"Dare Quam Accipere," by T. B. Layton (Clinical Lecture) 24
Deaths 10, 22, 34, 46, 58, 70, 94, 110. 122, 146, 158, 170, 182a, 206a, 226, 244, 268, 280a, 296, 308, 322
Debating Society 307
Declining Reproduction Rate, by P. L. Masters 200
Dental Curriculum 236
Teaching at Guy's Hospital, The History of, by F. N. Doubleday .. 96
Dermato-Myositis, A Case of, by R. O. Barber 150
Dickens' Birthday Celebration .. 36
Digitalis, by Maurice Campbell .. 259
Diseases of the Herd, by T. B. Layton (Clinical Lecture) 160
"Distinguished Gathering" 42
Doherty, W. D., Tuberculosis of the Urinary Tract 40
Doubleday, F. N., The History of Dental Teaching at Guy's Hospital, 1795–1895 96
Retirement of, ... 83
Douthwaite, A. H., To Those Entering the Clinical Period 233
Dramatic Society 83
Farnborough Hospital, "George and Margaret" 155

E

Earache, by W. M. Mollison 84
East, W. Norwood, Clinical Aspects of Crime 47, 48, 60
Entry of Students, October, 1945 .. 254
Epitheliomata, Superficial, and Chronic Arsenical Poisoning, by L. Forman (Clinical Lecture) 287
Evans, T. J., Relinquishes Position of Dean of the Medical School .. 258

F

Farnborough Hospital, Play at .. 43
Dramatic Society, "George and Margaret" 155
Fencing Club 251
Football, Association 45, 240
v. Borough Road College 45
v. Cambridge University 45
v. Norseman 280
v. Old Finchleians 267
v. R.A.C., O.C.T.U., Sandhurst .. 9
v. Royal Marines (Chatham) .. 268
v. St. Bartholomew's (Inter-Hospital Cup—Semi-final) 109
v. St. Mary's Hospital 307
v. St. Thomas's (Inter-Hospital Cup —Final) 109
Rugby 35, 59, 239, 269
Fixtures, Season 1945–46 .. 267
Inter-Hospitals Cup Draw .. 319
Résumé of Season 1944–45 .. 121
v. Aldershot Services 45, 295
v. Cambridge Univsrsity 294
v. Coventry 68, 322
v. Devonport Services 322
Inter-hospital Seven-a-Side Competition 122
Middlesex County Seven-a-Side Competition 121
v. Middlesex Hospital 45

PAGE

Rugby—*continued*
v. New Zealand Services 56
v. Nuneaton 266
v. Old Merchant Taylors 267
v. Old Paulines-Cranleighans .. 280
v. R.N.E.C., Keyham 8
v. Rosslyn Park 321
v. Rotol, Gloucester 93
v. St. Mary's Hospital .. 9, 69, 307
v. United Hospitals 8
v. United Services (Portsmouth) .. 267
Forman, L., On Superficial Epithelio-mata and Chronic Arsenical Poison-ing (Clinical Lecture) 287

G

"George and Margaret," Farnborough Hospital Dramatic Society 155
Gillespie, R. B., An Appreciation .. 284
Death of 269
Psychological Medicine and the Family Doctor 216, 228
Glomerulo-nephritis, Factors Modify-ing the Clinical Features and Course of, by A. A. Osman (Clinical Lecture) 310
Grasly, E. W., Pembury at War .. 275
Greaves, Miss S. M., Awarded George Medal 96
Guy, Thomas, Statue of 111
Guy's to Keats 265
Guy's Notables, Lesser Known, Charles Turner Thackrah, by G. Payling Wright 301
Guy's Hospital Chapel, Broadcast from 135
Clubs' Union 238
Dental Teaching at, 1795–1895, The History of 96
During War, Illustrations 210
Etching by Hanslip Fletcher .. 184
Front Surgery 47
Gazette, J. P. M. Bensted resigns Editorship 12
M. Hall elected Editor 196
Rodney Long appointed Sub-Editor 297
J. Reinhold resigns Editorship .. 196
Martin Thorne appointed Editor .. 12
resigns Editorship 297
And the German War 172
Letter, Christmas, 1944 4
Medical School, Dr. E. R. Boland appointed Dean 258
Notes on Some Early Surgeons to, by R. R. James 17
Re-opening of Wards 228
In the 'Seventies, by "An Old Resident" 12
Student Singers, Broadcast .. 297
Team at Belsen 204
Guy's *v.* King's (Illustration) 125
Students' Life at 257
Vacancies on the Visiting Staff .. 281
Visit of Her Majesty the Queen 112, 124

H

Hale-White, Lady, Death of 309
Hall, Michael, Elected Editor of *Guy's Hospital Gazette* 196
Handley, W. Sampson, The Pre-vention of Cancer 72
Her Majesty the Queen, Visit to Guy's Hospital 112, 124
Hill, Adrian, Hyperemesis Gravidarum 290
History of Dental Teaching at Guy's Hospital, 1795–1895, by F. N. Doubleday 96
History of the Signs, by Hugh Barber 196
Hockey 240
v. Blackheath 307
v. Gravesend 322
v. Middlesex Hospital 108

PAGE

Honours, Birthday 147, 182a
Civil Awards 46, 82, 96
New Year 22, 34
See also The Services ...
House Officers—Sector 10 58, 156, 225, 278
Hyperemesis Gravidarum, by Adrian Hill 290

I

Illustrations—
Guy's Team at Belsen 204
v. King's 125
during War (Supplement) .. 210
Visit of Her Majesty the Queen to Guy's 124, 151

J

James, R. R., Notes on Some of the Early Surgeons to Guy's Hospital .. 17
Johnstone, D. F., Acute Plastic Bron-chitis (with Case Report) 2
Johnston, T. B., Awarded C.B.E. .. 2

K

Keat's Anniversary 265
Kinder, C. H., A Case of Multiple Swellings of Undiagnosed Origin .. 190
Kummel's Disease, A Case of, with Secondary Pathologies, by R. O. Barber 115
Kyte, Nora Lucy, Obituary 179

L

Landon Tea Fund 297
Lawn Tennis Club 250
Layton, T. B., "Dare Quam Accipere" (Clinical Lecture) 24
Diseases of the Herd (Clinical Lecture) 160
Life and Literature 298
Resumes Duties at Guy's 258
Leave in Rome, by C. W. Marshall .. 163
Life and Literature, by T. B. Layton .. 298
Lloyd, V. E., Congenital Syphilis in the Infant 270
Long, Rodney, Appointed Sub-Editor of *Guy's Hospital Gazette* 297

M

MacNab, Mr., Retirement from Front Lodge 245
Macrae-Gibson, A. C., Obituary .. 208
Malaria at Guy's 221
Marriages 10, 22, 34, 46, 70, 82, 94, 122, 146, 182a, 194, 206a, 226, 244, 268, 280a, 298, 322
Marshall, C. W., Leave in Rome .. 163
Masters, P. L., The Declining Repro-duction Rate 200
Medical Co-education 35
Medicine Extraordinary 68
Mistletoe: or How Dr. Myocardium Came to Specialise in Hearts, by Harold Neate 320
Mollison, W. M., Earache 84
Mullins, M. R., Death of 12
Obituary 27
Music Club 279

N

Neate, Harold, Mistletoe: or How Dr. Myocardium Came to Specialise in Hearts 320
New Year Honours 22, 34
"Night Must Fall" 169
Notice, Astley Cooper Studentship .. 194, 206a

PAGE

Boat Club Centenary Ball .. 243, 280
Dental Society Annual Dance .. 226
Guy's Hospital Dental School, Demonstrator in Operative Dental Surgery 268
Nurses' League 110
Students' Union 46
Hunterian Lectures by Guy's Men 308
Medical School Appointments .. 10
National Provincial Bank, Ltd. .. 82
Resident Medical Officer to Nuffield *House* 226
Rugby Football. Jerseys Wanted .. 182
Visit of Paris University 280
Students' Union 256
York Clinic, Department of Psychiatric Medicine 82
Nuffield, Lord, Statue to 147
Nursing Profession, To Those Entering 237

O

Obituary, Lt.-Col. G. T. Birdwood, I.M.S. (ret.) 101
Harold Chapple 77
Robert Clark 258
R. G. Gayer-Anderson 163
R. D. Gillespie 284
Nora Lucy Kyte 179
A. C. Macrae-Gibson 208
Captain M. R. Mullins 27
Alfred Salter, An Appreciation .. 221
Guy Bellingham Smith 126
Ogilvie, W. H., Appointed Vice-President of the Royal College of Surgeons 172
To Those Entering the Surgical Wards 234
Ophthalmology, Thyrotoxicosis in Relation to, by O. G. Morgan (Clinical Lecture) 148
Orpington, Christmas at 5
Orpington Letter 192
Osman, A. A., Factors modifying the Clinical Features and Course of Glomerulo-nephritis (Clinical Lecture) 310

P

Pains in the Legs in Children, by H. C. Cameron (Clinical Lecture) 209
Papers by Guy's Men 10, 34, 46, 69, 82, 122, 158, 170, 182a, 206a, 244, 268, 308
Passim 1, 11, 23, 35, 47, 59, 71, 83, 95, 111, 123, 135, 145, 159, 171, 183, 194, 207, 215, 227, 245, 257, 269, 281, 297, 309
Pass List, Conjoint Board 10, 22, 82, 134a, 170, 194, 280a, 295
Royal College of Physicians, M.R.C.P. 46, 58, 296
Royal College of Surgeons, F.R.C.S. 182, 296
L.D.S. .. 58, 134a, 280, 296
Society of Apothecaries of London 10, 22, 46, 69, 110, 134a, 170, 214, 244, 296
University of Cambridge 34, 58, 182
University of London, B.D.S. 34, 214, 244
M.B., B.S. 46, 110, 182, 214, 243, 244, 280, 295, 308
M.D. 214
University of Oxford .. 110, 182, 280
Pembury at War, by E. W. Grasby .. 275
Penny, E. A., Keats' Anniversary .. 265
Physiological Society 262
Post-Graduate Studies 11
Prize Examination, Awards 122, 182, 280a, 296
Psychological Medicine and the Family Doctor, by R. B. Gillespie .. 216, 228

Q

PAGE

Queen, Her Majesty the, Visit to Guy's 112, 124, 151

R

"Rag," Guy's *v.* King's 125
Reinhold, J., Resigns Editorship of *Guy's Hospital Gazette* 196
Reproduction Rate, The Declining, by P. L. Masters 200
Reviews—
Angove, Remedial Exercises for Certain Diseases of the Heart and Lungs 19
Bailey, Physical Signs in Clinical Surgery 19
Pye's Surgical Handicraft .. 28
Borradaile, A Manual of Elementary Zoology 242
Breen, Fevers for Nurses 104
British Journal of Surgery, Penicillin in Warfare 20
Craddock, Prosthetic Dentistry .. 203
Dobbin and Mackenzie, Salts and their Reactions 203
Ewart, A Guide to Anatomy .. 28
Foote, Varicose Veins, Hæmorrhoids, and other Conditions. Their Treatment by Injection 28
Gardner, Bacteriology for Medical Students and Practitioners .. 6
Garry, Prevention and Treatment of Disease in Warm Climates .. 103
Gunn, An Introduction to Pharmacology and Therapeutics .. 104
Haler: Aids to Clinical Pathology .. 106
Ham: "Doctor in the Making"; or the Art of Being a Medical Student 64
Henderson and Gillespie: A Textbook of Psychiatry 152
Hewer: A Text-book of Histology for Medical Students 102
Hine: Manual of Diseases of the Eye 64
Illingworth: Text-book of Surgical Treatment 64
Kampmeier: Essentials of Syhpllology 101
Lewis: Exercises in Human Physiology 102
J. R. S. McDowall: Handbook of Physiology and Biochemistry .. 202
MacManus, Nursing in Time of War 19
Matthews, The Surgery of Repair .. 19
Nesbit: Transurethral Prostatectomy 105
Pannett: Surgery 20
McLachlan: Handbook of Diagnosis and Treatment of Venereal Disease 6
Pavey: Clinical Procedures and their Background 243
Plesch: The Blood Pressure and its Disorders including Angina Pectoris 103
Ritchie: Thomson's Outlines of Zoology 104
Roberts: The Trial of Harry Dobkin 54
Rolleston and Moncrieff: Industrial Medicine 29
Rycroft: A Manual of Ophthalmology for Medical Officers .. 318
B. Solomons and E. Solomons: A Handbook of Gynæcology .. 105
Stafford-Clark: Sound in the Sky and other Poems 21
Taylor: Battle for Health; a Primer of Social Medicine 151
Walshe: Diseases of the Nervous System 319
Zieve: Aids to Orthopædic Surgery and Fractures 106
Ribs, Fractured, and other Chest Injuries, by R. C. Brock (Clinical Lecture) 184
Roll of Honour 282
See also The Services.

PAGE

Rome, Leave in, by C. W. Marshall .. 163
"*Rope*" 119
Ryan, Miss, Retirement of 159
Ryle, John A., Clinical Discipline 112, 127, 136

S

Sailing Club 181, 278
Salter, Alfred, An Appreciation .. 221
Senior Training Corps, University of London 238
Services, The 34
Awards 10. 22, 34, 70, 110, 122, 158, 170, 182a, 206a, 226, 268, 308
Casualties 22, 34, 70, 122, 158, 244
Sharp, Samuel, Surgeon 52
Shield, Sister, Retirement from Dental Department 215
Simpson, Keith, A Letter from Mr. T. B. Layton 154
What to Do with a Dead Body .. 138
Silent Revolution, by H. St. H. Vertue 246
Smith, Dorothy M., Appointed Matron, Guy's Hospital 281
Smith, G. Bellingham, Obituary .. 126
Southcombe, Mr., Appointed Head Porter 147
Southwark Cathedral, Handel's "Messiah" 36
Squash Rackets Club 44, 241
Starlets No. 6 33
Students, Entry of, October, 1945 .. 245
Life at Guy's 257
Union, ... 252
Styloid Process, Exploration of the Region between and the Transverse Process of the First Cervical Vertebra, by Patrick Clarkson .. 100
Surgical Wards, To Those Entering, by W. H. Ogilvie 234
Swellings, Multiple, of Undiagnosed Origin, A Case of, by C. H. Kinder.. 190
Swimming Club., *v.* Bishop's Stortford College 169
Syphilis, Congenital, in the Infant, by V. E. Lloyd 270

PAGE

T

"Take Your Medicine" 143
Thackrah, Charles Turner, by G. Payling Wright 301
Theatre Club 253
Thorne, Martin, appointed Editor of *Guy's Hospital Gazette* 12
resigns Editorship of *Guy's Hospital Gazette* 297
Thyrotoxicosis in Relation to Ophthalmology, by O. G. Morgan. (Clinical Lecture) 148
Tuberculosis of the Urinary Tract, by W. D. Doherty 40

U

Uncle Harry, Changing Clinical Horizons 165
University of London, Senior Ttaining Corps 238
Urinary Tract, Tuberculosis of, by W. D. Doherty 40

V

Vertue, H. St. H., A Silent Revolution 246
The Burning Question 88

Wards at Guy's Hospital, Re-opening of 228
Warren, Mr., Retirement of 96
Wass, S. H., Appointment of Hunterian Professor 172, 308
What to Do with a Dead Body, by Keith Simpson 138
Whitbread, Mr., Retirement of .. 96
Wildernesse Garden Party .. 135, 208
Wittrick, Miss Florence, An Appreciation 258
Awarded M.B.E. 147
Retirement of 258
Women Students 71
Wright, G. Payling, Lesser Known Guy's Notables: Charles Turner Thackrah 301

Y

York Clinic Report on, Felix W. Brown 129

Wills Library

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1473 *6th January, 1945* *Ninepence*

PASSIM

THE year 1944 has been an eventful one, both in the history of the world and in our own smaller sphere, the history of Guy's Hospital. It has marked the release of many of the oppressed nations from under the Nazi yoke and has furnished the prelude to the final defeat of Germany and to the destruction of her desperate bid to achieve world domination.

Here, at Guy's, the changing face of the war has affected us to no mean extent. In the early months of the year the renewal of enemy bombing raids over London kept us on the alert, though, providentially, there were but few casualties to deal with at this time. As Spring came upon us, speculation as to the date of our great Allied invasion of the Continent became widespread and, when on June 6th our forces landed on the enemy beachheads, surgical and X-ray units from Guy's were ready waiting at strategic points near the South-East Coast to receive the first casualties. Many of us were not called upon to undertake these tasks and, consequently, felt rather disconsolate at our lot. In July, however, we were attacked by a new form of missile, the flying bomb, and then the services of every available man at the Hospital was required. In a remarkably short time an efficient and smooth-running system was developed for dealing with the casualties that came in and, enlightened by its experience in the "Blitz," the Hospital carried out its work to the utmost of its ability. As was only natural, teaching suffered in the emergency, many of the wards had to be evacuated and non-essential operations were postponed until a more propitious time; however, it reflects greatly to the credit of the Dean and teaching staff that this gap was filled as soon as possible and that temporary measures to extend the teaching facilities were quickly adopted.

Guy's itself suffered no direct damage as a result of these attacks, although the playing fields were temporarily put out of use. Since these momentous times things have quietened down considerably, and although Hitler's latest piece of villainy—the rocket bomb—occasionally disturbs our sleep, we have not found that it has caused any great inconvenience to date. However, we are not being lulled into any false sense of security, and the enemy has yet to outwit the ample preparations of Dr. Bishop, who has apparently provided for practically every contingency.

The teaching staff has undergone many notable changes this year; in the earlier months we lost both our Medical Registrars—Dr. French and Dr. Tillmann—who left us to join the Army. Great as was this loss, we were extremely happy to welcome in their place Dr. Neville Southwell, from the Middlesex Hospital, and Dr. Gerald Thomas, our erstwhile Medical Registrar at Farnborough. On the surgical side Mr. Jones left us early in the year and was succeeded by Mr. Douglas Jackson, who came to us from the Southern. This year has also seen the passing of two famous Guy's physicians—Sir Arthur Hurst and Dr. John Fawcett; much has been said in honour of these two men who gave so much to Guy's and to Medicine, and we have all felt their loss deeply. Another familiar figure in the Hospital will be missed when Mr. Layton leaves to take up his duties in Sicily; although absent, however, he will have left his mark at Guy's and the fruits of his teaching will remain with us.

The return of the Medical School in May from their temporary exile in Tunbridge Wells has done much to revive the fast-withering social and political life of the Hospital; the Students' Union has taken on a new lease of life; dances, debates and other social amenities have been organised, and a new paper "*Pulse*" has been published. To satisfy the material needs of this influx, the old dining-room in the College was rehabilitated and the catering staff, rising nobly to the occasion, have been feeding the augmented population of the Hospital ever since. Another feature of

the year has been the opening of York Clinic for the benefit of psychiatric cases, with the nursing under the guidance of Sister Purcell; the time of opening was, unhappily, inauspicious, as it practically coincided with the onset of the flying-bomb raids.

Finally, we must end with a word to the future; the year has seen the formulation of enormous plans for the rebuilding of the Hospital; these are as yet only in an embryonic stage and are liable to a great deal of readjustment. Let us, however, look forward to a new Guy's rising out of the dust of the old, yet retaining that inherent nature that embodies the spirit of the Hospital and let us hope for victory and peace in the New Year so that this ideal may be achieved.

WE must congratulate Professor T. B. Johnston on his award of the C.B.E. (Civil Division) in the New Year's Honours List.

Acute Plastic Bronchitis (with Case Report)

BY D. F. JOHNSTONE, M.R.C.S., L.R.C.P., D.P.H.,

Medical Superintendent, City Isolation Hospital, Plymouth.

PLASTIC or fibrinous bronchitis is a rare affection and may occur in either chronic or acute form. The latter type is much less common, and Norris Landis states that the recorded cases are not much over two hundred. A search of recent literature shows that very little has been written on the subject, and it may therefore be of interest to consider briefly some of the features of the disease in conjunction with the clinical aspects as illustrated by a case which occurred a year or two ago in this hospital.

The cause of the disease is quite unknown, but often there is a history of recent infectious disease or of chronic bronchitis. It has been described as occurring in association with the inhalation of irritant vapours, tuberculosis and heart disease. Some have attributed its onset to a metabolic disturbance, somewhat akin to the process found in membranous colitis, but so far no very satisfactory explanation has been forthcoming.

As a rule it tends to attack the younger age-group from ten to thirty years, and is twice as common in men as in women. The essential pathological process is the formation of bronchial and tracheal casts, composed of varying amounts of fibrin and mucin, cast formation being preceded by an acute inflammation of the mucous membranes lining these structures. The fully developed casts are then wholly or partially expelled after paroxysms of cough and dyspnœa.

Usually the prognosis is fairly good and most acute cases recover. The chronic form, however, is less serious, but recurrences are liable to take place, perhaps after many years, resulting in chronic pulmonary emphysema.

The following case-history is fairly typical of the clinical features of the disease and is worth recording, particularly in view of the excellent specimen of a tracheal and bronchial cast, a photograph of which is reproduced.

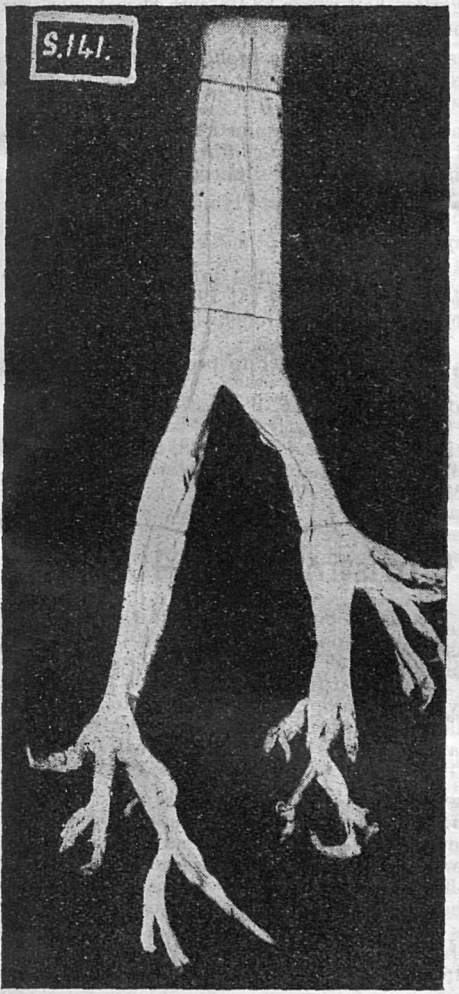
CASE HISTORY.

At 10 a.m. on February 3rd, 1940, I was asked to see a student nurse who had that morning reported sick with a "cold on the chest." She was a well-built, healthy country girl, aged twenty-one years, who had never been ill except for the minor ailments of childhood, and whom I had passed as physically fit several weeks before, on her entry into the service of the hospital.

On examination her temperature was 103, pulse 140 and respiration 30. The throat was clean and the only physical signs found were in the chest, where numerous moist rales and rhonci were heard over both lungs. She had a very troublesome cough, felt hot and uncomfortable, but did not appear seriously ill. I made a diagnosis of acute bronchitis, prescribed a simple cough mixture, ordered inhalations of tinct. benzoin co., and warded her for further observation and treatment.

I saw her again at 2.30 p.m. and, although she seemed rather poorly, her colour was good, and I was not unduly anxious about her condition. The same evening

showed little change in her general state, temperature 102, pulse 136, but the respirations had risen to 38, so I prescribed sulphapyridine in one gramme doses orally every four hours. (*Note.*—In 1940 the indications for sulphonamide therapy were less precise than now.) The physical signs in the chest were the same as when I first saw her.



She had a poor night and slept only for short periods as her cough had become much more troublesome.

At 6 a.m. on the following morning (February 4th, 1940) I was summoned urgently as she had suddenly become very distressed and complained that she was choking. On arrival I found her to be suffering from an acute attack of expiratory dyspnœa, coupled with a harassing cough and extreme cyanosis. After a short time she expectorated a large greyish-white cast, followed by much frothy and blood-stained sputum. Immediate amelioration of her symptoms occurred and she was soon in a deep sleep.

I made a diagnosis of acute plastic bronchitis and saw her again at 10 a.m., as her condition had again given rise to anxiety. She was cyanosed, dyspnœic, and bringing up much frothy blood-stained expectoration.

During the day she became progressively worse, dyspnœa, cough and cyanosis all becoming more pronounced, but no further attack of really acute dyspnœa ensued until 5 p.m. the same evening, when a similar attack to the one she had experienced that morning occurred.

Large doses of vin ipecac. by mouth, apomorphine subcutaneously, and tickling the pharynx failed to produce emesis, and continuous nasal oxygen gave but little relief to her distress. At this stage the characteristic flapping sound (*bruit de drapeau*) was heard on inspiration and her condition was indeed desperate.

At 7 p.m. that evening her anxiety and distress was pitiful. She was slowly suffocating, but was quite unable to dislodge the obstructing casts. Further hypodermic apomorphine was given without effect and an attempt at postural drainage produced only a few strings of ropy mucous. The cyanosis, however, seemed a little less while continuous oxygen was being administered.

At midnight there was a further attack of acute dyspnœa. Nothing gave relief, and in view of her desperate plight I performed a tracheotomy and extracted further casts by means of long membrane forceps. This gave temporary relief for a short time, but she gradually lost consciousness and died a few hours later.

Permission was not given for a post-mortem examination.

COMMENT.

A fatal case of acute plastic bronchitis is described occurring suddenly in a healthy girl of twenty-one. In this case there was no history of recent infection, tuberculosis or previous attacks of bronchitis. The diagnosis of the disease presents few difficulties, but, naturally, in a fever hospital, the first to be excluded was a primary laryngeal diphtheria, but although this possibility was considered, I have never seen it occur in an adult, as laryngeal involvement is almost always secondary to an extensive faucial angina. In addition, she was Schick negative, had never had a sore throat, nor was there any abnormality of the throat throughout her illness.

From the first the clinical picture was that of an acute bronchitis and, when the attacks of dyspnœa started, they were expiratory in character, whereas the dyspnœa of laryngeal diphtheria is always inspiratory.

Dr. E. Wordley, pathologist to the hospital, kindly examined the cast for me and reported: "Cast of trachea and bronchi composed mainly of fibrin; I presume this is a case of fibrinous bronchitis. I can find no evidence of diphtheria."

I have to thank Dr. T. Peirson, Medical Officer of Health, Plymouth, for permission to publish this case.

REFERENCES.

SEILER, S. Ueber Bronchitis plastica. (Mit Mittellung eines durch Kollapstherapie geheilten Falles.) *Schweiz. Med. Wchnschr.* 72, 86–90, Jan. 24, 1942.

ROTH, O. Zur Pathogenese und Behandlung der Bronchitis fibrinosa. *Klin. Wchnschr.* 17, 1798–1800, Dec. 17, 1938.

RAKOWER, J. Atelectasie massive au cours de la bronchite pseudo membraneuse primitive. *Presse med.* 46, 116–118, July 16, 1938.

MEYER, A. Ueber Bronchitis fibrinosa acuta. *Klin. Wchnschr.* 16, 1126–1127, Aug. 7, 1937.

SZAJNA, M. Case of fibrinous bronchitis. *Polska gaz. lek.* 16, 748, Sept. 26, 1937.

FRANK, E. S. Case of essential plastic bronchitis cured by bronchoscopic treatment. *Maandschr. v. kindergeneesk.* 6, 313–319, May, 1937.

Guy's Letter, Christmas 1944

THERE has been, not unexpectedly, a social boom at Guy's. It started during the second week in December and still goes on. Though mostly inspired by Christmas some events were arranged quite independently. One was a Brains Trust to commemorate the departure of Mr. Layton for Italy, at which Mr. Layton himself was a "brain." Questions chosen varied from opinions on the White Paper and public schools to a more flippant, yet hardly unimportant, discussion on the intermarriage of doctors and nurses. There has also been what, it is hoped, will not be the last game of mixed hockey at H.O.P. Guy's might even take on one of the bases.

The Christmas Season itself was inaugurated by Mary Ward the Friday preceding Christmas Day. It was a fine throw-off and caused those Sisters a good deal of anxiety who were arranging parties to follow. But their fears were never justified and each ward prepared one or more teas which outshone last year's efforts, however good those may have been. Somehow there was or had been a patient attached to each ward whose aunt's cousin or mother-in-law knew where all sorts of unlikely luxuries could be got, and—what was more important—got them. Decoration provided occupational therapy for weeks before Christmas and several students and nurses revealed artistic talent never dreamed of.

So Christmas Eve arrived with great carolling (and Dr. Saunders on the trumpet!) and Christmas Day dawned to the accompaniment of carols from a party of students and nurses; they sounded delightful from between the blankets. Mr. Gowing carried off Father Christmas at Sister Bird's out-patient party very well. The party itself was just a little trying to anyone who had been out on Christmas Eve!

Miss MacManus invited the residents to dinner with the nurses in the Home that evening. Appetites were a little blunted here and there by numerous confections eaten continuously through the day. Later a large party of nurses and students was entertained to a dance "Underneath the Arches." We hope this will still function next year, even though war and shelters have been discarded. There was only one nurses' dance this year, and it was held in the Sisters' dining-room. Just before it

there was a cocktail party given by the residents—which accounts for a lot. The maids' dance was a tremendous success, in spite of the fact that the strain of Christmas was beginning to tell.

The New Year, as last, was seen in quietly. The noise of the bells on the crisp, clear moonlit night—the first New Year they had heralded for so long; the hoarse yet foreboding sirens from tugs on the river contributed to produce the most moving and lasting impression of this festive season. From those now at Guy's let me wish to all who, for one reason or another, have left or been called away—a Happy and Prosperous 1945. D. R. S. S.

The Children's Party was held on Christmas Day this year from 2 p.m. to 4.30 p.m. and was a great success. There were about one hundred children, and Mr. Murray Pilser, the band-master who is so well known to the children, gave an entertainment as good as always. After community singing and competitions held on the platform, the children dispersed to tea round the Christmas-tree, which was very well decorated and there were gifts for every child. These were distributed by Father Christmas after tea. As the children went out they were given apples, nuts and Smith's Crisps, and walked home having had a very enjoyable afternoon.

Our thanks are due to many members of the Staff and firms in the neighbourhood who helped us immensely by giving money, decorations, food, etc.; and practically the whole of the Christmas-tree decorations were provided by the nurses themselves.

SISTER BIRD.

Christmas at Orpington

THE good ladies of Orpington—the Matron, Sister Dornan, the Sisters, Miss Barnes and her staff, by their wondrous exertions and achievements, have kept up Christmas this year better than ever before, and those who know Orpington know what this implies. What labour and forethought have gone into it beforehand is beyond my pen to describe. But one thing is sure: there never was a time when all the toil and the trouble of preparation under adverse conditions have been more worth undertaking. Christmas this year has been a much-needed tonic; would that one could prescribe as good in a bottle.

Our revelry began with a party given by Mr. and Mrs. Laurenson in honour of Sisters Benson and Smith, who are leaving, to our regret.

Of our good host we say in Pickwickian phrase that "he is a kind, excellent, independent-spirited, fine-hearted, hospitable, liberal man!"

So through Christmas we moved from gaily decorated ward to ward, each with its beaming hostess, its cheerful throng, its indescribable air of good-will; for Orpington, after many vicissitudes, has come into its own at last and honours Christmas in its heart all the year. The pantomime has been the outstanding achievement (given for patients on Boxing Day afternoon and staff in the evening; domestic workers and others on December 27th.) Forgive me you whose performances I enjoyed and appreciated but do not mention. It is a matter of space. The brunt of it was borne by five—The Cat (Nurse Gubbins), nigh worthy of the Lane in its palmy days; Dick Whittington (Nurse Few), who not only has a lovely voice, but also good looks, good manners, charm and dignity; Eliza (Sister Davies), who has the genuine comic force and spared herself not one whit to get the most out of it; Idle Jack (Miss Cranley), who threw all her brilliant cheerfulness into the part; and, lastly, the producer, Mrs. Bevan, who doubled this function with the part of Alderman Fitzwarren, and did it very well. Then there was graceful V.A.D. Nurse Neal and her Fairies, and there was the chorus. Surveying the latter one perceived how excellent is the catering in the Nurses' Home, and how superb the female physique it produces and maintains.

There is more to come—a Sisters' dinner, a fancy-dress dance as a New Year celebration, but, unless your scribe has cause to change his mind before the end, what he loved the most was the carol-singing of the nurses. Conceive the clear, cold, starry night, sweet voices ringing through the frosty air, the good familiar uniform, the capes turned round to show the cheerful red, pale lanterns glimmering and the silver moon shining down. Could you imagine anything more beautiful? They sang to us and, whether to admire most the excellence of the singing, the earnestness that was put into it, or the fair spirit that looked forth from the singers' countenances, I know not. They sang the carols with a descant that would have moved a heart of brass. H. ST. H. V.

Reviews

Handbook of Diagnosis and Treatment of Venereal Diseases. By A. E. W. McLachlan, M.B., Ch.B., D.P.H., F.R.S. First edition. Edinburgh: E. and S. Livingstone. Illustrated. Pp. 364. *Price* 15*s.*

THERE have always been many difficulties in providing satisfactory instruction for the medical student in the management of venereal diseases. Unlike all other medical conditions, the investigation and treatment of these diseases are necessarily conducted in an atmosphere in which we strive to fulfil the promise of confidence and privacy for the patient. The practical teaching of undergraduates in the clinic and the maintenance of conditions of secrecy and privacy for the venereal patient are directly incompatible. Every school which undertakes the training of medical students is forced to make some compromise between these two incompatibles, and, as a result, achieves a blend that varies in form, in different schools, as the stress is laid on practical training in the clinic on the one hand or theoretical instruction by means of lectures and occasional demonstrations on the other hand.

The medical student is, therefore, in greater need of a sound handbook on the venereal diseases than almost any other special subject. He needs a work which is small or of moderate size and inexpensive, yet well proportioned in scope between practical instruction and theoretical knowledge; the work must be well illustrated and well indexed.

Dr. McLachlan makes a reasonably successful attempt to fulfil these requirements in a new book of some 350 pages in which the material is of necessity very much condensed. Syphilis, which occupies about three-fifths of this work, is dealt with in some 200 pages. The visible lesions are well described and the appropriate illustrations are excellent. Methods of treatment are fully described and the schedules for injections are clearly and conveniently set out in tabular form. In early syphilis treatment by injections of neoarsphenamine and bismuth preparations follows orthodox lines. For tertiary syphilides, however, as many as seven courses of these injections over a period of 115 weeks are advised, during which the intervals without treatment never exceed three weeks. Such prolonged treatment, no doubt, is required for some of the refractory cases, but all this seems somewhat excessive for benign cutaneous lesions in elderly patients in whom the lesions may be healed within a few weeks.

There is little indication given of the results of the treatment advocated for the various stages or lesions of syphilis. Judgment on this score seems to be frequently left to the imagination of the reader, who, apparently, is free to assume that all early cases are equally curable. The inclusion of an analysis of results of treatment, statistical or narrative, would enhance the usefulness of this book.

A brief but pithy section on gonorrhœa deals effectively with this disease and its complications in the two sexes. The instructions for the irrigation treatment of the urethra and the chapter on the use of the urethroscope are especially lucid and practical. Among other conditions commonly seen in venereal disease clinics, the author deals briefly but adequately with such conditions as soft sore, venereal warts, non-gonococcal urethritis, balanitis and trichomonas vaginitis.

That there is no reference to the national venereal diseases scheme for treatment nor to recently introduced public health measures, such as Regulation 33B, is, no doubt, due to the limitation of the book to its present small and convenient size.

This handbook is well produced; the illustrations and colour plates are of excellent quality; and a generous index is provided. V. E. L.

Bacteriology for Medical Students and Practitioners. By A. D. Gardner. Third Edition. Published by Oxford University Press. London: Humphrey Milford, 1944. Pp. 264. *Price* 8*s.* 6*d.*

THIS third edition comes six years after its predecessor and incorporates without increase in bulk a number of the recent advances in the subject. Professor Gardner emphasises "the wider biological relations of microbe and man," and the book is an essay in pure, rather than applied, bacteriology. Judicious selection and skilful writing combine to produce a book which is at once sufficiently informative

for general purposes and extremely readable. The book suffers from the disadvantages inherent in a work of its size; there is room only for conclusions and none for experimental evidence. The discussion of the different types of bacteria is well done, with one exception. Considering the contemporary importance of the subject, a little more might have been said about the Clostridia. The concluding chapters on general immunology and disinfection are admirably done. The former contains a good account of Landsteiner's fascinating work on the chemical specifity of antigens and of Marrack's 'lattice theory" of antigen and antibody combination. The latter contains some interesting information on some of the newer disinfectants such as the chloroxylinols, C.T.A.B., and penicillin. In addition, there is a brief chapter on the important protozoa and fungi.

Brief accounts are given of the methods of applied bacteriology; but there still remains a need for a good short book on applied bacteriology, which should describe the bacteriological methods in everyday use, their potentialities and limitations, and especially their interpretation. There is also a need for a short work on another aspect of applied bacteriology which, in a world of social medicine, is going to become of increasing importance—epidemiology. Perhaps one might be permitted to suggest that Professor Payling Wright should write it. R. E. I.

Correspondence

INTERNATIONAL CONTACTS IN MEDICINE.

To the Editor of the GAZETTE.

SIR,—Your editorial of December 9th, 1944, in which you referred to the advantages of personal international contacts in medicine, and, in particular, your quotation, "Let our young men . . . go abroad," prompts me to report a recent conversation I had with a professor of the Medical School of Louvain.

After expressing a similar opinion, he went on to say that arrangements for students need not be lavish. A bed and a roof over his head was pretty well all that a student required. Lectures, demonstrations, conducted tours were easily arranged. Hospitality in families would, undoubtedly, be forthcoming.

In fact, the cost to the visitors need be little more than the travelling fare, and to the hosts need be very small. And the advantages to be gained need no description. And with most Continentals speaking English and most of us a little French, language should present little difficulty, even with Europeans.

I am writing merely to show that the desire for such an interchange of visits is present abroad. It would be a friendly gesture if the first move came from us, and as soon as the War permits.

Yours, etc.,

W. F. D.

LIGHTING OF GORDON MUSEUM.

To the Editor of the GAZETTE.

SIR,—These days many lovers of the Hospital are following with interest the proposals and suggestions for the rebuilding and development of Guy's, but as the greater part of the construction will not materialise for some little time, may one put forward a suggestion towards an improvement which could, perhaps, be executed in the near future? The improvement to which I allude is in the lighting of the Gordon Museum.

For some time I have been struck by the uneven distribution of intensity of illumination in the Museum, and recently I undertook a simple photometric survey of this building, using an electric photometer and recording readings from an arbitrary scale, since one was concerned only with relative luminosities. The intensity was measured at the top specimen-shelf but one in each gallery, and the maximum and minimum intensities were recorded. Since the galleries on the first "floor" share the illumina- of the upper galleries, the intensities at the first "floor" were measured first with the lighting of that "floor" only, and then when reinforced by the lighting of the upper "floor."

The maximum intensity of illumination in the whole museum was found to be on the bone-tumours, diseases of lymphatics and epithelia gallery, when this was lit solely by daylight entering *via* the skylight which was partly obscured by a blind. The intensity here was greater than any obtained with artificial lighting, and was taken to be 100 per cent. The percentage intensity in various other parts of the museum was found to be :—

Gallery.	Maximum per cent.	Minimum per cent.	Maximum reinforced. per cent.	Minimum reinforced. per cent.	*Remarks.*	
C.V.S. and C.N.S. ..	25	4	—	—	Daylight.	
Gynæcology ..	15	3	—	—	Artificial light.	Upper galleries.
G.U. and breasts ..	15	0.5	—	—	,, ,,	
Livers	23	1	—	—	,, ,,	
Bone tumours, etc.. .	100	—	—	—	Daylight.	
Forensic	25	4	50	8	Artificial light.	Lower galleries.
Bones, fractures, etc.	8	1	20	5	,, ,,	
Lungs	6	0.5	20	4	,, ,,	

These results were obtained with artificial lighting, save for the two exceptions noted.

The conclusions reached from this simple survey are two-fold—firstly, that the minimum intensity of illumination on the " bottles " on the upper shelves, when lit by the existing electric lamps, is but ½ per cent. of " filtered " Borough sunshine in November ; and, secondly, that great variations of intensity exist, both in different and along the same galleries, causing " pools of darkness." It was further noticed that the wattage of the brightest lamps was 100, while that of the dimmest was only 40. The illumination on a gallery lit by 100-watt lamps is adequate and free from glare, and the " pools of darkness " are practically inappreciable to the eye.

May one suggest, therefore, that replacement of the lower wattage lamps in the Museum by 100-watt lamps, and, ultimately, increasing the diffusion of the lighting by increasing the number of lamps or, better, by using diffused tubular lamps, would greatly improve the lighting of this building and would make the study of the specimens even more stimulating.

Yours, etc.,

W. E. EVANS.

Farnborough County Hospital,
Farnborough, Kent.

SQUASH RACKETS.

To the Editor of the GAZETTE.

SIR,—I was interested to read in the *Gazette* of December 9th, 1944, that the upkeep of the squash rackets courts amounted to more than £100 annually.

It was disclosed at the last general meeting of the Students' Union that they were affiliated with the Clubs' Union. I feel sure that I speak for many when I suggest that the club-room be made more comfortable.

The cost would be less than the upkeep for the squash courts and would be appreciated by a greater proportion of students.

Yours, etc.,

JACK FINE.

Guy's Medical School,
London, S.E.1.

Sport

Rugby

GUY'S *v.* UNITED HOSPITALS.

(At Richmond Athletic Ground, on Saturday, November 18th, 1944.)

Last season the Hospital should have played United Hospitals as part of the centenary celebrations, but, owing to fog, the match was cancelled, and the United Hospitals Committee most graciously offered to play us this season. The match took place at Richmond, on the Athletic Ground, the scene of all the inter-hospital cup battles, and resulted in a win for the representative side by 2 goals and a penalty goal (13 points) to 2 penalty goals (6 points).

The United Hospitals, under the captaincy of D. J. B. Johnston (St. Mary's), had not selected their strongest XV, but behind the scrum the St. Mary's pair, V. Morris and N. M. Hall, played with their usual brilliance, and, with C. D. McIver, the Middlesex three-quarter, formed a formidable triangle, which Guy's found it difficult to frustrate. That they were able to do so for most of the game is a

tribute to the excellent tackling, and in this respect the Guy's forwards excelled.

Of the two sets of forwards, Guy's were undoubtedly better all round as a pack, especially in the loose, where their concerted play frequently gained them a lot of ground and repelled several menacing attacks.

Our three-quarters never really got going until midway in the second half, when the ball was flashed out to the wings with such speed and accuracy, that a score seemed possible on more than one occasion. It was gratifying to see N. K. Macrae-Gibson trying everything he knew to send the newcomer, W. Selley, through, and if P. L. Brangwin had not been compelled to play full-back, following an injury, Guy's might easily have sprung a surprise.

Guy's opened the scoring with a penalty goal kicked by P. L. Brangwin, but the United Hospitals got our defence in a tangle, which resulted in P. I. Rutherford (King's College Hospital) crossing for a try, which N. M. Hall converted from the touch line, and this was the score at half-time.

The opening stages of the second half was a battle between the forwards, with Guy's having the best of it, but occasionally N. M. Hall got his backs moving, without, however, being able to beat our defence. Guy's were penalised for an infringement in the line-out, from which N. M. Hall kicked an easy goal.

It was following this that Guy's really looked dangerous, with grand bursts by A. Batty Shaw, P. S. Carton-Kelly, and then I. H. Hilliam, followed by two nice runs by N. K. Macrae-Gibson and W. Selley. The United Hospitals, however, gave away a penalty from which P. L. Brangwin kicked the goal.

In turn, P. L. Brangwin prevented B. J. R. Simpson (London) from crossing, then W. Selley was held up, but N. M. Hall cut through and made a nice opening for C. D. McIver to score under the posts for N. M. Hall to convert.

In view of the Hospital's record this season this performance should give the team more confidence, and convince the backs the value of swift and accurate passing to the wings.

Team.—B. M. Gray; P. J. Dwyer, N. K. Macrae-Gibson, P. L. Brangwin, W. Selley; K. Pritchard, R. D. Willcock; A. Batty Shaw (captain), C. H. Kinder, R. A. Dean, I. H. Hilliam, A. G. McCallum, C. P. Mills, S. M. Hilton, P. S. Carton-Kelly.

GUY'S *v.* R.N.E.C., KEYHAM.

(*At Honor Oak Park on Saturday, December 23rd, 1944.*)

In view of past performances, the victory over the Royal Naval Engineering College by 2 tries to a goal, was a tonic much needed, and no doubt, will help the team to regain their confidence.

With the Medical School on vacation, difficulty was experienced in raising a XV, but on the morning of the match, P. L. Brangwin sportingly agreed to turn out on the right wing, which enabled J. M. Pugh to move to scrum half as partner to N. K. Macrae-Gibson, no other half-backs being available. P. J. Dwyer, returning after his injury, had J. D. Shaw in the centre with W. Selley on the left wing, with B. M. Gray at full-back.

At first sight the back division looked extremely experimental, but as the game progressed, the three-quarter line worked with more smoothness and guile than at any time during the season. A. B. Lee had more of the ball from the set scrums, and the backs brought their wings into the play so frequently that the line always looked dangerous, with P. L. Brangwin particularly outstanding in his bursts which gained a lot of ground. The forwards had more confidence in the backs, whom they fed repeatedly, despite the heavy ground.

Early on, Guy's had a nice three-quarter movement which sent W. Selley over, but P. J. Dwyer and B. M. Gray were up in support of the loose ball, but the credit for the try goes to W. Selley. The College took the lead somewhat luckily, when P. J. Dwyer was unable to clear his lines, and E. D. Harwood touched down for J. H. M. Lang to convert.

The second half saw Guy's indulging in some really fine movements. P. J. Dwyer made a fine run, but W. Selley dropped the final pass; P. L. Brangwin got away on three or four occasions; and I. H. Hilliam made a break away, and a kick ahead, which nearly led to a score.

The winning try came from a scrum following an unfortunate knock-on by P. L. Brangwin a few yards from the line. The ball flashed across to the left wing, where W. Selley crossed from an accurate pass by P. J. Dwyer.

GUY'S *v.* ST. MARY'S.

(*At Teddington on November 11th*, 1944.)

Result: St. Mary's 13 points,; Guy's nil.

In the game against St. Mary's Hospital at Teddington on Saturday, November 11th, Guy's showed by far their best form for this season, with the result that though St. Mary's won by 3 tries and a dropped goal to nil, they found it no easy task. It is a tribute to the faultless tackling of the backs and the excellent play of the forwards that such a brilliant team as St. Mary's should have found such opposition.

The first half consisted mainly in a hard forward fight, Guy's trying to keep the ball amongst the forwards as much as possible and the St. Mary's forwards trying to feed their backs. In the tight scrums both sides shared the ball equally, though in the loose Guy's showed greater liveliness and were able to nip many a potential movement by the St. Mary's three-quarters in the bud. Amongst the Guy's forwards the ubiquitous Vidot more than lived up to his name and was outstanding throughout the game, and gave Hall and Morris, that excellent pair who would give speed to any movement, much to worry about. The first score came after a clever passing movement by the St. Mary's backs, which ended in a try by E. K. Scott, which was unconverted. It came, I think, as a great surprise to St. Mary's that they were only leading by 3 points when half-time came.

After half-time the play speeded up considerably and two unconverted tries, scored by N. M. Hall and R. W. Watson for St. Mary's, brought the score to 9–0, and then more very even play followed until a beautifully dropped goal by N. M. Hall brought the score to 13–0, just before the final whistle was blown. In the second half the play was more open than during the first half, and the tackling of all members of the Guy's three-quarter line was at times bordering on brilliance, but they were unable to prevent the excellent play of Hall, Watson and Morris from producing a well-deserved win for St. Mary's, though it should be a great encouragement to Guy's that they should have put up such a magnificent fight against such experts.

Association

GUY'S *v.* R.A.C., O.C.T.U., SANDHURST.

This match was played at H.O.P. on Saturday, December 16th, at H.O.P., and resulted in a draw, 2–2.

This was a very hotly-contested game and Guy's did well to draw against a heavier and

much fitter side. Sandhurst opened the scoring half-way through the first half of the game, after making several dangerous attacks on the Guy's goal. The score at half-time was one goal each, A. E. Trist having equalised shortly before the change-over.

Guy's now pressed hard, but failed to complete their movements in front of goal; Sandhurst's left wing took advantage of a through pass and scored easily, catching the Guy's defence on the wrong foot. E. G. Murphy scored the equalising goal five minutes from time.

Team.—G. H. Garland, A. W. R. Williamson, F. R. M. Young (captain), E. M. Newton, C. S. Matthews, A. R. Merrill, R. A. C. Dove, E. G. Murphy, A. E. Trist, W. A. Evans, G. Roberts.

Hospital Information, etc.

Notices

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the appointment of Acting Surgical Registrar and Tutor (B 1 Post) from suitably qualified registered practitioners (Male) holding B 2 appointments. Registered practitioners now holding B 1 appointments and rejected by the R.A.M.C. may apply.

Applications are also invited from Medical Officers recently discharged from the Services.

Salary will be at the rate of £550 or £350, according to experience, with board and lodging or £100 per annum in lieu thereof. An additional honorarium will be paid by the Medical School for teaching duties.

The successful candidate will be enrolled as a whole-time officer in the Emergency Medical Service.

Applications with copies of recent testimonials to be sent to The Dean, Guy's Hospital Medical School, London Bridge, S.E.1, not later than Friday, January 19th, 1945.

Pass List

CONJOINT BOARD.
December, 1944.

Chemistry.

D. J. W. Foster	K. S. Sunaway
G. Holding	R. D. F. Thiel
D. K. Minton	R. L. B. Turner
G. G. Phillips	P. J. F. Woodroff
B. S. Saunders	

Physics.

D. J. Murch	B. S. Saunders
D. L. Rees	T. G. Skinner
W. G. Selley	G. P. J. Williams

Elementary Biology.

P. J. Attenborough	D. G. Brett
R. D. Baker	D. G. Bunker

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
December, 1944

Pathology, Bacteriology and Forensic Medicine.—*A. G. I. Stockley.
Medicine.—*A. G. I. Stockley.
* Has completed the examination.

Change of Address

F. Bocquet Bull, M.R.C.S., L.D.S., 15, Upper Wimpole Street, W.1. (Tel.: Hop 1848.)

H. John Croot, Lieut.-Col., R.A.M.C., 126 I.B.G.H. (B.T.), Poona, India.

D. Hand-Bowman, Captain, A.D. Corps, O.C. 532 Mobile Dental Unit, 17 Fd. D.S., B.L.A.

C. R. Morgan, Captain, R.A.M.C., 27 L.A.A. Regt., R.A., B.L.A.

N. A. Neville, Surg.-Lieut., R.N.V.R., H.M.S. *Nabthorpe*, c/o G.P.O., London.

F. N. Van der Pant, L.D.S., R.C.S., 37, Devonshire Place, W.1. (Tel.: Welbeck 8331.)

R. S. Vine, Lieut.-Col., R.A.M.C., 174 Highland Field Ambulance, B.L.A.

Papers by Guy's Men

Hale-White, R. Life Assurance. Some Medical Aspects. *Post-Grad. Med. J.*, 1944, 20, 303.

Layton, T. B. The Voluntary Hospital with an Undergraduate School. *Lancet*, 1944, ii, 743.

Jacoby, N. M. Pyloric Stenosis; Selective Medical and Surgical Treatment. *Lancet*, 1944, ii, 748.

Haslewood, G. A. D., and Another. Antibacterial Action of 2-Aminophenol. *Brit. Med. J.*, 1944, ii, 754.

Punch, A. Lisle. Acute Lobar Pneumonia. *Practitioner*, 1944, **153**, 336.

Gillespie, R. D. Psychological Medicine. *Practitioner*, 1944, **153**, 297.

Dunnill, D. E. Apparatus for Continuous Pentothal. *Brit. Med. J.*, 1944, ii, 793.

Awards

M.B.E. (Military Division).

Major E. L. Elliott

(M.O. to 4th Batt. Bucks Home Guard).

Marriages

BODMAN—THORNTON. — On December 16th, 1944, in the British Church, Naples, J. M. Bodman, W/Cmdr., R.A.F., to Miss D. E. Thornton, P.M.R.A.F.N.S/R.

Births

PORGES.—On December 17th, 1944, at Guy's Hospital, to Dorothy (née Billington), wife of Karel I. Porges—a son (Peter John).

Deaths

ASHBRIDGE.—On November 5th, 1944, E. D. Ashbridge (radiographer, Guy's, 1920–26)—30, Glengall Road, Woodford Green.

GOODALL.—On November 29th, 1944, Edwin Goodall, C.B.E., M.D., Lieut.-Col., late R.A.M.C.—Fairlawn, Kingsway, Hove, Sussex.

SALSBURY.—On November 25th, 1944, Archibald Frank Salsbury, Lieut.-Col., A.D. Corps.

THOMAS.—On December 22nd, 1944, at Lyme Regis Cottage Hospital, William Murray Thomas, M.R.C.S., L.R.C.P.—Chideock, Dorset.

EDS. { J.P.M.B.
J.D.L.R.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1474 *20th January, 1945* *Ninepence*

PASSIM

SURGEON-LIEUTENANT GEIDT'S letter, in our Christmas Number, raises a problem which will affect all the present generation of students as well as the men who have gone before us into the Services. The subject of post-graduate education has, however, much wider implications than the letter deals with, and to consider our own problem adequately we must briefly review the whole issue. Post-graduate education in this country is a comparatively recent innovation; the British Post-Graduate School was founded in 1935, and the Fellowship of Medicine, which provides facilities for overseas students, was only established at the end of the last war. The reason for this tardiness has mainly been a lack of organisation of the existing opportunities provided in the London Medical Schools. Now, however, a great future in post-graduate education has been opened up by the report of the Goodenough Committee. This report comprehensively covers the whole subject and it is roughly divided into two main groups—post-graduate education for specialist trainees, which involves a detailed course of some five years study; and post-graduate training for general practitioners. We will not consider the former group any further at present, as it is only the latter which will affect the majority of us in the near future. Although this group deals mainly with the problems of established medical practitioners, its main implications apply equally well to those doctors now serving in the armed forces, and although special emergency arrangements may have to be made for the latter, the nature of their medical course will be essentially the same.

The British Medical Association Memorandum divides this course into three components:—

1. "A "brushing-up" of the knowledge which all general practitioners should possess. This should include a revision of—(*a*) the ætiology, diagnosis, clinical course, and treatment of the illnesses with which the practitioner is in daily contact; and (*b*) methods for the maintenance of health, including nutrition and dietetics, child health, and antenatal and postnatal care.

2. Instruction in recent advances in diagnosis, treatment, and prognosis. with particular emphasis on methods which can be applied by the general practitioner unaided.

3. Instruction in recent advances in the diagnosis and treatment of common diseases which cannot be applied by the general practitioner unaided, but a knowledge of which should form part of his equipment."

It is proposed at present that the Undergraduate Medical Schools shall not be employed in giving these refresher courses, and so it seems likely that old Guy's men would not come back here for their post-graduate rehabilitation; they may rest assured, however, that adequate arrangements are being made elsewhere and that they will not be unloosed on to the general public with only a knowledge of cyphering, censoring, triplicating and the running of wine accounts.

IT is always well to know what the outside world thinks of us and in view of this we are sure that you will countenance the following reprint from the *New York Herald Tribune*, of Monday, October 8th, 1944, by their sports writer, Mr. Stanley Woodward:—"London, Oct. 8.—Your agent went back to the old beat yesterday, covering a football game in the afternoon and a series of boxing matches in the evening. The football was Rugby: Middlesex Hospital 11; Guy's Hospital, 3, at Honor Oak Park. . . . . The Rugby teams were strictly war-time. Only a few of the performers looked like real athletes. As a matter of fact they were medical students, who work so hard under current acceleration that they don't have much time to practise football. Neither team seemed to me to be in a class with the Cambridge team that went to America a

few years ago and slaughtered such Rugby forces as we could muster. They played one-way ball, monotonously feeding by stages to the wing, who generally was collared on the sideline.

One of the Guy's made a great tackle in front of the grand stand and an excited Old Blue jumped up and shouted: 'Well floored.'

Politeness, not to say frigidity, reigns at Rugby. The clients tended to look askance at the visiting American and answered questions with such lack of warmth that we stopped asking them.

Rugby is not polite on the field. It is rough and rugged, and the game this department saw produced one broken shoulder, one broken ankle, and one sprung knee.

The British allow no substitutions, and inasmuch as Guy's suffered all the injuries, 'Sex had a three-man advantage in the last minutes and used it to score one penalty kick, one try and one conversion, thus breaking the 3-all tie. Mangling the enemy pays off in Rugby.

What they need over here, perhaps, is an Asa SmithBushnell, to defy the stuffies and change the rules to permit a modicum of protective armor.

Incidentally, certain American maneuvres could be employed in Rugby, even under the current laws. This department saw half-a-dozen situations in which a naked reverse would have gone for a touch. The old sideline sleeper play is also possible, though the ball is harder to throw than ours, being fatter.

The game as it is does not appeal to your agent as much as British professional Soccer. There the skill is beyond belief and the friendliness of the common people who attend makes the American feel at home."

In spite of his somewhat quaint phraseology it seems abundantly evident that the "department," Mr. Stanley Woodward, is not impressed by the game of Rugby football; although this in itself is unimportant, we feel that the last sentence of his article implies an indictment which we would do well to consider seriously.

ANNO DOMINI has again taken its toll, and last week we sadly bade farewell to the departing Editor, Mr. J. P. M. Bensted; we welcome Mr. M. G. Thorne in his place to the Assistant Editorial chair.

WE would remind our readers that the annual subscription to the *Gazette* and *Directory of Guy's Men* (*Medical and Dental*), 12*s.* 6*d.* per annum, post free, is now due; and, to save paper and postage, it would be appreciated if they would kindly forward the same to the Manager, *Gazette* Office, Guy's Hospital, S.E.1.

IT is with deep regret that we have to report the death in Italy of Captain M. R. Mullins, B.M., S.A.M.C. We hope to publish an obituary shortly.

Guy's in the Seventies

By "AN OLD RESIDENT"

ENTERING as a second year's student (having done some preliminary work at Cambridge), I went through the usual courses of anatomy and physiology in the dissecting-room and the laboratories and found myself for the most part, working with men a year or two younger than myself and among them only one or two who had had the advantage of public school or university training. In those days the teaching, except as regards chemistry, was all in the hands of the Honorary Staff of the Hospital for the time being.

The Senior Physicians and Surgeons delivered set lectures on anatomy, physiology, pharmacology, etc., while the Assistant Staff undertook the work of demonstrating and class-teaching. There were no professors or whole-time demonstrators, and the quality of the instruction given was by no means as uniform as it might have been. By far the best lectures which I had to attend were those given on physiology by Dr. F. W. Pavy, who was recognised at that time as the leading authority on the subject of diabetes. He took great pains to make his teaching intelligible to the average student, and often illustrated his meaning by actual demonstration on the living subject, a method which carried more conviction in a few minutes than any amount of oral description. One such demonstration dwells in the memory, where he undertook to show how the heart's action may be restored after failure by artificial

respiration. The thorax of a large dog being rapidly exposed so that heart and lungs could be clearly seen, the cardiac action soon began to fail and when it had ceased altogether, a supply of oxygen was forced into the lungs by a pump and, after a few such inflations, the cardiac pulsations returned and continued in fair strength so long as the regular supply of oxygen was maintained. The dog of course, was completely anæsthetised and died with the closing of the demonstration.

The teaching of miscroscopic anatomy was of a very elementary type, but we learnt how to recognise most of the normal tissues, without the use of stains or chemical preparation. I do not remember whether there were any special classes for the study of morbid tissues, but with a rough-and-ready method of freezing and section cutting of our own, we managed to acquire a fair knowledge of the diseased tissues most frequently met with.

The Honorary Staff of the Hospital in the year 1874 was composed for the most part of physicians and surgeons of a pre-bacteriological era, but new ideas were beginning to be introduced by some of the younger men, whose teaching naturally attracted the better class of students.

Dr. (afterwards Sir) Samuel Wilks, although his days of activity were practically over, was still a clinical teacher whose methods of diagnosis were a revelation to those students who had hitherto been accustomed to think only in terms of the disease with which the patient was assumed to be afflicted, rather than with the actual morbid conditions as presented by the individual case. Careful observation of the symptoms and common sense interpretation of their indications did not always fit in with the rules laid down in the text-books or even with the expressed opinions of recent authorities, but were rarely at fault when applied in treatment.

Students of text-book medicine were sometimes disappointed that Dr. Wilks often failed to prescribe orthodox remedies or even any medicaments at all, but left the treatment in the hands of his house-physician. He, nevertheless, kept a sharp eye on all such cases as really required drug treatment and was particularly watchful over anxious cases. A very large proportion of the patients in the medical wards of a large hospital recover their health by way of rest, judicious feeding, warmth and attention to bowels. Physic three times a day plays no real part in their convalescence, but human nature, in gentle and simple alike, seems to crave for a " remedy."

Perhaps the most popular physician of that time was Dr. Walter Moxon, a very lovable personality with a strong leaning towards philosophic thought and argument, but a careful clinician and an interesting teacher, although his vivid imagination often carried his thoughts far above the heads of the crowd of students who followed him round his wards.

I was his house-physician for six months in 1878 and became much attached to him, and was often invited to his house on Sunday evenings, where he used to start subjects for argument and sometimes put forth preposterous notions with a view to " drawing " the argumentative powers of his younger guests.

Dr. Hilton Fagge was then the Senior Assistant Physician and at that time acted as pathologist, whose chief duties were to make the post-mortem examinations. In later years he wrote a text-book on general medicine which was generally accepted as the book of the day and his teaching during my period of acquaintance with him was marked by constant reference to the opinions and writings of other authorities, mostly German or Viennese, which he was constantly encountering in his researches. Hence as a clinical physician he did not carry much weight.

Tragic days fell upon Guy's Hospital Medical School during the years of the 'nineties. One after another no less than five of its most able and promising men fell victims to disease in early or middle life. The names of Moxon, Hilton Fagge, Mahomed, Carrington and Washbourne, all of whom seemed destined to add to the fame of the School, were in turn removed, long before they had reached the best of their life's work.

A very valuable rule prevails at Guy's whereby the bodies of all persons dying within the Hospital may be subject to post-mortem examination. Hence a vast amount of material for the study of pathological anatomy is available for students at all stages of their career.

Each of the physicians in turn acted as pathologist, the rough work being performed by students as " post-mortem clerks." When the duty fell in his turn upon Dr. Moxon, he introduced the wearing of rubber gloves to protect the hands from possible inoculation by septic tissues. The precaution was a novelty and for a time was derided but has since become universally adopted. A former physician, Dr. Owen Rees, who

had only recently retired, happened to look in on the post-mortem room one day and saw these gloves in use. "Hallo, Moxon, how's this? 'Puss-in-mitts' won't catch many mice, I'm afraid"—but the sarcasm fell rather flat.

Post-mortem revelations always interested me and during the period of my house-physiciancy in 1878 I was often called upon to make the examinations on behalf of the pathologist, who might be engaged elsewhere with more profit (to himself). On one occasion (Good Friday, 1878) there happened to be five bodies waiting for inspection, when neither the pathologist nor the post-mortem man could be got at. I managed to complete them all, single-handed, making the official reports also, without assistance of any kind. A day's work to remember, but not to repeat.

Opportunities for clinical study by the ordinary student were far greater in those days than they are now. The resident officers were fewer, there being only two house-physicians and two house-surgeons, together with two obstetric residents, known as the "Senior and Junior in Charity."

Each surgeon was attended by three full dressers who held office for six months each, in turn becoming "dresser-for-the-week" when his chief was "taking-in." This meant that all cases recommended for admission, whether from the surgery or the out-patient department had to pass through his hands before actual admission. Hence, during his week of "taking-in," the "dresser-for-the-week" was an important person and the responsibility for selection of cases and possible rejection of others, called for rapid and careful decision and no little tact in dealing with the doubtful cases.

During the week following he fell from his high estate and became for the next week the "ex-dresser," charged with all sorts of odd jobs such as the extraction of teeth in the surgery, the giving of subcutaneous injections in the wards, and generally acting as the handy man in emergencies. Among his other duties he had to keep an eye on the supply of beer and tobacco in the "rooms" where the resident staff had their meals and generally foregathered. Incidentally, it may be recorded that the quantity of beer consumed in these rooms did not pass exclusively down medical throats, a special barrel being drawn upon for the benefit of the police constables who brought accidents, etc., to Guy's in preference to other hospitals—but it is probable that similar arrangements were made in the other institutions also.

The work of the Surgery, to which all cases of accidents are admitted in the first instance, was greatly helped by the practical experience of elderly nurses, especially at night, whose judgment as to the severity or otherwise of each case could generally be relied upon. As house-physician I occupied rooms in a separate building, connected by a speaking-tube with the Surgery and the old Irish nurse in charge, when calling me up at night never failed to add a hint such as "You needn't hurry" or "You'ld best look sharp," which generally proved to be correct advice.

Very strange cases are apt to crop up among the cases that apply for relief, by day or night, at the surgery of a large hospital. Comedy and tragedy succeed one another with startling rapidity and, although the latter prevails, the former is by no means absent from the daily round of work.

At one time a huge van would come rattling up to the gates, and excited drivers and bystanders would rush to assist in carrying a small child who was stated to have been run over by the van. Abundant evidence was forthcoming as to the fact, the child's clothing bearing distinct marks of the wheels, but the child himself seemed to be in no way perturbed by all the fuss that was being made on his behalf, and evidently wondered what it was all about. Actually, on examination, no evidence of injury could be found. The van, bumping and bouncing along over the rough pavement must have jumped over the child's body without hurting it. In contrast to such a case, one might note the arrival of a costermonger's barrow attended by a poorly-dressed woman and a rough-looking youth or two and laden with the body of a man, evidently badly hurt. With no excitement and hardly a word said, the patient is carried into the Surgery. The nurse promptly calls the dresser for the-week, who, after brief examination, orders the patient to be laid on a couch in one of the small rooms attached to the Surgery and allows the woman to remain in attendance, telling her in a few sympathetic words that the case is serious, but will be admitted to the wards if he recovers consciousness after the shock.

Only too often such recovery does not occur and the end follows quickly, the injuries being beyond the power of surgery to repair.

Perhaps the most dramatic entry into the Surgery occurred one night during my term of office, when a Clown and a Harlequin from the Surrey Theatre appeared in their stage costumes, bearing between them the terrified Columbine, badly burnt. The

poor girl, in the excitement of her dance, had approached too closely to the flaring gas footlights, which were at that time quite unprotected, and in a moment her gauzy skirts were in flames. Before they could be extinguished she was terribly burnt about legs and body, and was naturally in exquisite pain. For many weeks she lay in the ward, the very extensive destruction of skin being gradually replaced by grafts supplied by enthusiastic students, and she ultimately recovered. This case led to more drastic precautions being enforced in all the theatres using gas footlights.

During the hop-picking season, the London Brighton and South Coast and South-Eastern railways conveyed large numbers of East End hop-pickers from London Bridge Station (adjoining Guy's Hospital) to various parts of Kent and Sussex, running their trains during the night. Early in the evenings the large open space in front of the stations gradually filled up with expectant travellers and, long before the trains were timed to start, presented the appearance of a gypsy encampment, children being especially in evidence. Police control was not so well organised as it afterwards became, and pandemonium was the usual result. We at Guy's were kept busy between the hours of 10 p.m. and 2 a.m. in dealing with minor injuries, incapable drunks and distracted mothers in search of lost children, but serious casualties were rare.

Two striking cases of attempted suicide dwell in my memory, both thwarted by curious circumstances. A terrible disaster occurred in the Thames, involving the loss of a very large number of excursionists returning from a trip to Thanet in a paddle steamer, the *Princess Alice*, which had been sunk after collision with a large collier below Blackwall. Wild excitement was stirred up in Southwark and Rotherhithe, whence many of the excursionists had been drawn. A young man was brought into Guy's in a state of rigid convulsion and was stated to have poisoned himself with strychnine on hearing that his *fiancée* had been on board the ship. It appeared that he had rushed into a chemist's shop and asked to be supplied with strychnine. The chemist wisely supplied him with a harmless powder, labelled "Poison," and after swallowing it the young man immediately started convulsions and apparently became unconscious. His symptoms, however, did not suggest strychnine poisoning but rather an exaggerated form of hysteria. This diagnosis was quickly confirmed by the administration of an injection of apomorphia, a drug that had only recently been introduced. Within forty seconds of the injection all the rigidity disappeared, vomiting ensued and, except for the weakness and lassitude which followed these proceedings, the patient soon recovered.

The second case was that of a young man who, for reasons unstated, had fired a pistol into himself directly over his heart. On admission he was almost collapsed, ashy pale, trembling, sweating, and apparently in great fear. Examination showed that a bullet had undoubtedly entered his chest, but there were no symptoms of damage to any internal organ. The bullet was found to be lying immediately under the skin of his back, having evidently glanced on a rib and run round the chest in the subcutaneous tissues.

Considerable amusement was caused one afternoon by a solemn-looking little boy, who came alone to the Surgery and asked to have a "toof" pulled out. He submitted to the extraction of the offending tooth and, when asked for his name, he said it was "Oliver Cromwell," and departed as quietly as he had come. Whether he was really entitled to that name it was impossible to say, but, at any rate, he showed a stoic indifference to pain worthy of his great namesake.

In 1876 Joseph Lister had come to King's College Hospital and his antiseptic methods of treating surgical wounds, and especially the wounds caused by operations, were attracting attention, but had not yet received general acceptance. Alone among the Guy's surgeons Mr. H. G. Howse had begun to use them and, during that year, I had the advantage of being one of his dressers. Some of the senior surgeons openly derided the new theories of "germs." I remember one of them telling the Sister of the ward that she had better "keep that door shut or we shall have some of Mr. Lister's germs walking in!" But as time went on the undeniable evidence of hard facts had to be recognised. Excisions of the knee-joint in cases of tubercular disease had been so uniformly unsuccessful under ordinary methods, that amputation was generally preferred, but when carried out with antiseptic precautions, recovery, in Mr. Howse's hands, became the rule and healing generally took place without a sign of suppuration. All his operations were conducted under a spray of carbolic lotion, the spray being "pumped" by junior students at first and, in later years, by steam sprayers. The antiseptic idea gave place in its turn to aseptic practice as now universally adopted, but not till long after my connection with surgery had ceased.

During my earlier years at Guy's the nursing was of the old-fashioned type ; training appeared to consist of practical methods only. Young women were engaged without much regard to education. They began work as " scrubbers " and by degrees were promoted to work in the wards as junior nurses, assisting the charge nurses who worked under the Sister. Thus they gradually learnt the routine of nursing without any explantion or understanding of the reasons for the things that they had to do, and were often found woefully wanting in common sense in dealing with unforeseen emergencies. A few of the more intelligent among them took some pains to learn all that their " Manuals of Nursing " could teach them and in their third year of service were promoted to be charge nurses, often having to act for the Sister during her absence. But in too many cases the ordinary nurses were little better than servants, more concerned with their own interests than with those of their patients. No proper provision was made for the supply of emergency nurses, and elderly women of the Mrs. Gamp type were too often found to be left in charge of difficult cases, especially at night.

During my house-physiciancy several such cases occurred and gave rise to remonstrance on the part of the medical staff, which resulted in a long controversy between the medical and lay authorities, which, unfortunately, became public property and supplied much material for comment in newspapers, music-halls, etc. A better system was gradually introduced, and the days when a case of diphtheria after tracheotomy could be left all night in the charge of a female known as " Silly Charlotte " have gone for ever.

Guy's was, I believe, the first of the large hospitals to run a paper of its own. The *Guy's Hospital Gazette* had been running for a long time before I joined the Hospital. It was generally edited by one or more of the senior students, usually the house-physicians for the time being, and in due course I had to act as co-editor. There were many old customs in vogue at that time which seemed offensive to the more enlightened students of the day and the columns of the *Gazette* afforded opportunity for these matters to be ventilated. Such comments, however, were unpleasing to the lay authorities and I was taken to task for impudence in allowing them to appear and, for a time, the *Gazette* was suppressed by order. But the reforms which it had advocated were quietly introduced as time went on and, its sins being forgiven, the *Guy's Hospital Gazette* has appeared fortnightly ever since. Most of the large school hospitals now publish their own papers, but after sixty years the *Guy's Hospital Gazette* may claim pride of place.

In my time the students attached to the Hospital enjoyed nothing in the way of a residential hostel or college, but had to live in lodgings and provide for themselves in every way. Lant Street in the Borough still existed and, in many of the dingy streets round about, the landladies of the type of Mrs. Raddle catered for the wants of the Guy's students very much as in Bob Sawyer's days, and there were still a few of the Bob Sawyer and Ben Allen type to be found, but they were rapidly becoming extinct under the stricter supervision of the school authorities.

Accommodation was found in " The Rooms " already referred to, for the eight resident officers who were always on duty—two house-physicians, two house-surgeons, two obstetric residents, the dresser-for-the-week and the ex-dresser. They took all their meals together and, as a rule, formed a very happy family, except when a grumbler appeared, which did not often happen. Friendships were formed, many of which have stood the test of time and are still as cordial as ever, although progress in professional life has been very varied. Four at least of my co-residents have risen to the top in their respective spheres, bearing such well-known names as Hale-White, Arbuthnot Lane, Charters Symonds, Henry Davy, Alfred George Barrs (of Leeds), but two of these have recently left us (1932). Of the active Medical Staff of those days only one remains, and it is a painful reflection that a very large proportion of the students also have departed, only too many of them by reason of illness contracted in the course of professional duty.

In the summer of 1893 I was invited to deliver an Introductory Address to the students of Guy's Hospital on the opening of the Winter Session of the Medical School, on October 1st. Such an Introductory Address, in previous years, had generally been delivered by older men of established reputation in the profession, and the selection of a younger physician, a student of the Medical School, was a new departure and I appreciated it very highly, all the more so as my old teacher, Sir Samuel Wilks, President of the College of Physicians, was in the chair, and many kind things were said about me on the occasion. The Address was published in full in the medical papers.

Notes on Some of the Early Surgeons to Guy's Hospital

By R. R. JAMES.

IT is often a matter of considerable difficulty to trace the parentage of people who were born in the later years of the seventeenth century. Wilks and Bettany, in the history of Guy's Hospital, state that very little is known about the first four surgeons elected to Guy's.

Some years ago I was given permission by the Court of the Barbers' Company to transcribe the records of apprentices which are preserved at the Hall; I can therefore fill in a few gaps in our knowledge of these men. I think it practically certain that Francis Croft, Guy's first surgeon, is the man of that name who had been apprenticed to John Browne,[1] and was admitted a freeman of the Company of Barber-Surgeons on January 22nd, 1694/95. I was not able to find the name and occupation of his father. There is a break in the entries on the apprentice books from July 20th, 1683, to May 1st, 1685. Croft, it will be seen, took up his freedom about ten years after this break, and though the usual period of apprenticeship was seven years, there are plenty of examples of boys being apprenticed for longer terms and a ten years' apprenticeship was by no means uncommon.

I believe that Francis Croft is identical with the Francis Crofts, who, in the Naval Records at the Admiralty, is entered as Surgeon on H.M.S. *Ranelagh* in January, 1701/02. In 1704–05 he was on H.M.S. *Barfleur*, and in December, 1705, he returned to the *Ranelagh*. He received two certificates for his service afloat. It is worth while remembering that his master, John Browne, had also served as a naval surgeon at the start of his career.

I am on much surer ground with Guy's second surgeon, Andrew Cooper, for Andrew, son of John Cooper, of Bittelby (Bitterley), Co. Salop, was apprenticed at the Hall to Lancelot Copplestone, surgeon, for seven years on June 4th, 1695. He took up his freedom on November 9th, 1703.

Cooper was baptized at Bitterley on July 6th, 1679. The record on the parish register is in Latin. Andreas, son of John Cupper and Lucy Cupper, is one of many variants in spelling of the name Cooper found at this time. The father served as churchwarden at about this date; but I do not know what his trade was. I expect he was a yeoman farmer. Bitterley, Cooper's birthplace, is a very remote parish under the Titterstone Clee Hill, about five miles from Ludlow. Andrew Cooper died on August 22nd, 1732.

Robert Baker was a son of Thomas Baker, of Chicheter (*sic*), Tallow-Chandler. He was apprenticed to Henry Bull,[2] surgeon, for seven years, on June 4th, 1702. Baker took up his freedom on June 9th, 1709. Wilks and Bettany state that he retired in 1733, but as his widow, Ruth, consented to the transference of one of his apprentices in that year, it is quite likely that he died in office. He is almost certainly the Mr. Baker, Chirurgeon, who died on July 24th, 1733 (*Gentleman's Magazine*).

Hasell Cradock occurs on the apprentice books as Hasel Craddock, son of Walter Craddock, of Wickham Brook, Co. Suffolk, Gent. He was apprenticed to Cheseldon for seven years on February 6th, 1720/21. His father paid a premium of £262 10*s*. He took up his freedom on February 6th, 1727/28, and on the freeman's Roll his name is spelt Cradock.

Samuel Sharp was the son of the late Henry Sharp, of Jamaica, and was apprenticed to Cheselden for seven years, March 2nd, 1724/25. The premium in his case was £300.

John Belchier was a son of James Belchier, of Kingston-on-Thames, Mercer. He was apprenticed to Joseph Tanner,[3] surgeon, for seven years, March 6th, 1721/22. The premium was £225. Later he was "turned over"[4] to Cheselden and he took up his freedom on April 1st, 1729.

I have not been able to identify the Mr. Pierce on Guy's surgical list in 1745, but, in order to complete the record of apprenticeships at Barber-Surgeons' Hall, I may note that Joseph Warner was a son of Ashton Warner, of Antigua, in the West Indies,

He was apprenticed to Sharp for seven years, on December 3rd, 1734. The premium in his case was £350. He became a freeman on December 1st, 1741.

In 1745 the Surgeons separated from the Barbers and the names of surgical apprentices are not found on the books after that year.

---

1 John Browne, surgeon to St. Thomas's Hospital, 1683–91 ; Surgeon-in-ordinary to Charles the Second and William the Third ; author of an anatomical and surgical treatise.

2 Henry Bull, Surgeon to St. Bartholomew's Hospital, 1722–28.

3 Joseph Tanner, Surgeon to St. Thomas's Hospital, 1719–1725.

4 When a barber-surgeon died or want out of business his apprentices, who were not out of their time, were " turned over " or transferred to some other master.

Correspondence

CLINICAL AND MEDICAL INSTRUCTION.

To the Editor of the GAZETTE.

SIR,—In a recent " Passim " you drew attention to the vast throng of students which Dr. Douthwaite attracts on Tuesday afternoons. Your remarks have not evoked criticism, comment or defence. Such a state of affairs has existed for some time and is clearly not satisfactory.

It is apparent that a clinical student at the Hospital is able to obtain instruction in surgery on five afternoons in the week. He can only obtain instruction in medicine on two afternoons. However, there appears to me to be an equal number of physicians and surgeons who teach us at Guy's. In my figures I include the three physicians who visit us from hospitals outside the sector, and the members of the special departments, excluding Skins, Psychological Medicine, V.D's., and Eyes.

While we, as students, fully realise the difficulties of our teachers, particularly their administrative duties, there are three constructive suggestions that I have to make. In the first place a number of physicians do ward rounds in the morning and only two in the afternoons. There is always at least one medical out-patient department on each morning in the week. So could it not be possible for some of the physicians' rounds in the morning to be changed to the afternoon ?

Secondly, the rounds by alternate physicians on Monday afternoon have not been held for six months. It was logical that they should cease in June, but cannot they now be restarted ?

Finally, there is the time of Friday afternoon. A letter in your columns recently showed how the present generation of students miss the weekly round by Sir Arthur Hurst. The crowd of thirty to fifty who regularly attended him was a testimony, not only to his own greatness, but was indicative of the lack of medical teaching elsewhere on that day. Could I humbly suggest that Professor Ryle be approached to become his successor on that afternoon ? I understand that the Department of Social Medicine at Oxford consists only of three people. It plans to commence serious activity after the War. When the Professor returns to this country could he not be spared to Guy's for Friday afternoons ?

Yours, etc.,

42, Trinity Church Square, S.E.1. A. BATTY SHAW.

EQUALITY OF OPPORTUNITY FOR ALL.

To the Editor of the GAZETTE.

SIR,—I was surprised to find the Editor of " Passim " (July 22nd) advocating discrimination against groups of his fellow-students.

I think the choice of the phrase " given away over the heads of M.B. students " is a most unfortunate one. That entry should be limited to M.B. students may be good policy from the point of the school and the individual, but in the meantime equality of opportunity for all the members of the school must continue.

Yours, etc.,

Office of the Surgeon,
Allied Force Headquarters. E. R. BOLAND.

Reviews

Physical Signs in Clinical Surgery. By HAMILTON BAILEY, F.R.C.S. 9th Edition. John Wright & Sons, Ltd.: Bristol. *Price* 25*s. net.*

THIS book is well known. It demonstrates the basic methods of examining patients and eliciting physical signs. The illustrations are profuse and, for the most part, very good; they are conveniently placed in relation to the text, the whole making light and easy reading. The book is useful for students at all stages of clinical work; it forms a good introduction of surgery to the ward clerk and serves well as a method of rapid revision for senior students in the pre-examination period. It must be stressed, however, that the book can in no way replace the actual contact with patients in the wards; here alone can surgery be learned. S. H. W.

The Surgery of Repair; Injuries and Burns. By Squadron-Leader D. N. MATTHEWS, R.A.F.V.R., M.A., M.D., M.Ch. (Cantab.), F.R.C.S. (Eng.). Oxford: Blackwell Scientific Publications, Ltd. 45*s. net.*

THIS book deals with common war injuries which come within the province of a plastic surgeon. These injured often receive immediate treatment from a general surgeon, and it is therefore desirable that he should understand the principles involved.

The substance of the book is divided into four parts—(1) immediate repair; (2) subsequent repair; (3) late facial repair; and (4) the treatment of burns. The first section deals with the immediate operative treatment of soft tissue injuries and facial fractures. Here is a full and clear account of middle third fractures of the face and fractures of the mandible. In the second part the various methods of repair of skin loss are described and well illustrated, and this leads on to the third section on the special problems of facial repair; here the nose, lips, eyes, cheeks and ears are dealt with in turn. The book concludes with a full account of the controversial subject of burns and all the modern methods of treatment of burns. F. R. K.

Remedial Exercises for Certain Diseases of the Heart and Lungs. By HESTER S. ANGOVE T.M.M.G. Published by Faber & Faber. *Price* 6*s. net.*

THE author, in the preface, states that the purpose of the book is to give the student in training a useful working knowledge of the subject, and to provide a reference book for those already qualified. These aims have been adequately fulfilled, and Miss Angove has given to the student of physiotherapy a book which has set out clearly and simply the causes, morbid anatomy and symptoms of certain diseases of the cardio-vascular and respiratory systems. The principles underlying the treatment of these various conditions, together with the methods by which they are carried into effect, have been carefully explained and illustrated.

Miss Angove is a pioneer in this field of work, and it is largely owing to her research and evolution of treatment by physiotherapy that sufferers from these conditions have been enabled to remain useful citizens, taking an active interest in the affairs of the country.

The book should prove a valuable acquisition to any medical library, and students of medicine and physiotherapy would gain much useful knowledge of the rehabilitation of cardiac and respiratory conditions from perusal of its pages. S. M. E.

Nursing in Time of War. P. H. MITCHENER and E. E. P. MACMANUS. Published by J. & A. Churchill, Ltd. Second Edition. *Price* 2*s.*

THIS little book has already proved its worth to nurses working under war-time conditions. The second edition will enhance its value, for it has been revised in the light of first-hand experience.

It contains a description of the organisation of the treatment of war casualties, nursing in first-aid posts, in converted hospitals and in huts and tents.

The later chapters deal with the treatment of burns, wounds, shock, fractures and other casualties. There are most helpful diagrams and illustrations.

It is a remarkable two shillings' worth and should be in the pocket of all nurses working under war-time conditions. F. T.

Penicillin in Warfare. BRITISH JOURNAL OF SURGERY. John Wright & Sons, Ltd.: Bristol. *Price* 12*s.* 6*d. net.*

IT is only two years since penicillin was "used on at least one case with some encouraging results" in North Africa. Already it is in supply as the most effective and least harmful antibacterial agent yet brought into clinical use. This timely volume lays down no absolute directions for the use of the drug, but describes actual clinical experiences with it in the following seven connections :—

1. *Principles of Use of Penicillin.*—It stresses the necessity of adequate dosage for adequate time to give the natural body defences time to deal with the infection.

2. *Soft Tissue Wounds.*—The value of penicillin here lies in the increased safety of primary suture, which results in reduced scar tissue, increased range of function, easier repair of nerves at a later date, speedier convalescence and simpler nursing.

3. *Compound Fractures.*—In an open fracture infection will turn multiple fragments from bone-grafts into sequestra. The conversion of an open to a closed fracture is a big step. A case is made for early closure of open fractures with the aid of penicillin—a practice which results in a lower mortality, rarer amputations and less toxæmia.

4. *Gas-Gangrene.*—Radical surgery is stressed as still being the keystone of treatment, but penicillin is claimed as being more powerful than the sulphonamides for chemotherapy.

5. *Chest Wounds.*—Intrapleural injections are shown to be more effective than parenteral therapy for pyothorax, and empyemata have even been cured without drainage.

6. *Head Wounds.*—Penicillin therapy for these cases is supplemented by sulphonamides, which, although much less effective than penicillin against meningitis, are more easily administered.

7. *Venereal Diseases.*—For gonorrhœa, especially the sulphonamide-resistant group, and for syphilis, penicillin is put forward as the best therapeutic agent. But with both diseases a high standard of care and adequate follow-up examinations will be required before a true estimation can be established.

The spectacular claims and extensive scope of penicillin in chemotherapy will cause many to read this special issue with pleasure and profit. The dullest aspect of the volume is the most important; it is the repeated warning that chemotherapy in wound treatment is ever and always secondary to adequate surgery. D. MACG. J.

Surgery. A Text-book for Students. By Professor C. A. PANNETT. 1944. Published by Hodder and Stoughton. *Price* 35*s. net.*

THE author's intention in the publication of this new text-book of surgery is "to ease the already heavy burden on the undergraduate student." To this end he has written *sans* pathology, *sans* differential diagnosis, *sans* operative details, special senses and gynæcology. The student, who still has to know these subjects to satisfy the examiner, will have to bear the burden of finding these elsewhere.

The descriptions of the common diseases are clear and readable and the author has refrained from including outworn paragraphs, faithfully copied from book to book until now (such as excision of actinomycosis). The illustrations are what they claim to be. "portraits of mental conceptions," and in the main illustrate the text; there are no photos, which, no doubt, accounts for the "boy holding nose and blowing out an aerocele in his neck," and yet no illustration of such a common condition as leukoplakia. The terminology is simple and orthodox, but a student who turns to a shorter surgery book may find panaris and bronchocele for whitlows and goitre an unnecessary tax on his memory.

This book is a good account of descriptive clinical surgery, but for the one-surgery-book-student it is hardly adequate. With added help on pathology, diagnosis and operations the author's wish for the student may come true—"Fortune (and the examiners) may smile on him." D. MACG. J.

Sound in the Sky and Other Poems. By DAVID STAFFORD-CLARK. Oxford: Basil Blackwell, 1944. Pp. 32. *Price 2s. 6d. net.*

GUY'S men and women will welcome another slim book by David Stafford-Clark. He shows himself a good self-critic by his title, for this seems the best :—

"Now summer's sky is filled with sound
At evening; in the clouds
The heavy bombers steer their course
Towards the sea; and on the ground
The tumult of their engines faintly stirs
Within our ears."

Then he joins this sound to the ground :—

"In cottage gardens, sweet flowers drink
Last dregs of colour from the fading light,
Their scent floats on the dusk, to link
With the now distant thunder of the engines."

And goes "within each aircraft's twilight" to take us with him to where :—

"—in anticipation, the defence prepares,"

until :—

"The next wave comes
As on the ground
The splintered ruins rock and roar with fire
And shrill notes end in cataracts of flame
Continuous, bubbling like a cauldron as the earth
Shudders and flies asunder."

Then he passes from the "battle's fierce confusion" to the "confusion in men's minds," and strikes a note that will remain for many a day.

"And you—will you but think on what he said
Your heart may share his truth
And your ears hear
Still, through the sound of bombers overhead,
On the dark air—his voice."

I like David Stafford-Clark's verse because it is largely monosyllabic, because it contains a flavour of that alliteration that has come down to us from the Anglo-Saxon, because his lines scan and there is an atmosphere of onomatopoiea. In short, it is English.

I like his poems because he observes, because he describes, because he feels and is thinking as well. He has developed since he wrote the verse in his former book. The love is deeper with friendship as sincere; and still his best goes out to his brother.

"You are beyond the beauty of this world
Though through it may your presence be made known
More real and instant than the body's sense,
Keyed to the world's perception.
So your soundless voice
No longer needs my ears, but speaks
Within my mind. No present vision claims my eyes
But a clear thought, that asks outright.
And your warm laughter that I once recalled
To answer grief, and still the agony of less.
I need recall no more; memory is transcended
By your true spirit's communion in my heart;
Glowing and fresh that will not be denied.
Is it too high a praise to say there is in this a touch of Adonais!"

T. B. L.

Hospital Information, etc.

Change of Address

R. W. B. Ellis, Wing-Cmdr., R.A.F., No. 8 General Hospital, B.L.A.

N. Hunt, Surg.-Lieut., R.N.V.R., H.M.S. *Gosling V*, c/o G.P.O., London.

L. J. Moir, Major, A.D. Corps, No. 51 Field Dental Laboratory, B.L.A.

B. W. Pett, Surg.-Lieut. (D.), R.N.V.R., H.M.S. *Nabaron*, c/o G.P.O., London.

Miss G. I. Sumpter, Q.A.I.M.N.S., 43 General Hospital, M.E.F.

Christmas Crossword Solution

PRIZEWINNERS

1st PRIZE

C. D. BULSTRODE, Guy's Hospital, S.E. 1

2nd PRIZE

P. A. W. LEA, Guy's Hospital, S.E. 1

Pass List

CONJOINT BOARD.
FIRST EXAMINATION.
December, 1944.

Anatomy.

N. Davis
H. D. G. Hope
K. M. S. Hume
T. G. Pugh
P. R. Wagner

Physiology.

K. M. S. Hume
I. D. Jones
E. T. King

Pharmacology.

J. F. Delafresnaye
D. A. Harris
C. D. Korn

ROYAL COLLEGE OF SURGEONS.
FIRST AND SECOND PROFESSIONAL EXAMINATION.
L.D.S.
December, 1944.

Dental Metallurgy.

A. A. Bailey
E. B. Busfield
T. R. Foster
B. M. Gray
M. B. Lacey
N. L. McIntyre
R. L. Simmons
C. R. Wilkinson

Dental Mechanics.

F. M. Scherbel
M. J. L. Sykes

Anatomy and Physiology.

H. E. Braun
M. W. Harber
D. G. D. Harris
J. K. Keen
D. W. Leatherbarrow
I. A. Nelson
A. P. Rowland
F. M. Scherbel
S. F. A. Westgate

Special Anatomy and Physiology.

D. W. Farren
R. Freeman
P. C. Matthews
L. M. Sycamore
A. J. L. Wheatley

CONJOINT BOARD.
FINAL EXAMINATION.
January, 1944.

Medicine.

*R. J. F. Campbell
E. L. Dutta
F. F. Jerichower
*D. O. Lloyd
*H. R. Lomax
*A. V. Morse
*D. P. Nicholson
J. D. Wallace

Midwifery.

E. R. Arnold
*R. G. L. Brittain
*N. R. Fenton
J. D. Huntley
*R. P. C. MacDonald
R. G. Wotton

Pathology.

D. G. Breeze
W. M. C. Hallinan
J. Lederer
H. A. R. Loxdale
R. D. Rogers
M. M. El Shinnawi
H. W. Topham
J. D. Wallace

Surgery.

E. R. Arnold
S. Davis
G. Forrester
R. A. Green
*M. V. Guilmant
W. T. Harrett
J. D. Huntley
*R. P. C. MacDonald
J. N. Micklem
*A. V. Morse
R. D. Rogers
D. J. Rudman
*D. P. Wheatley
J. D. Whitehouse

* Have completed the examination.

SOCIETY OF APOTHECARIES OF LONDON.
PRIMARY EXAMINATIONS.
October, 1944.

Materia Medica, Pharmacy and Pharmacology.—R. N. H. Vann.
Anatomy.—M. P. Cardew.
Physiology.—D. J. Crowther.

CONJOINT BOARD.
Diploma in Laryngology and Otology.
December, 1944.
N. A. Punt, M.R.C.S., M.R.C.P.

Death in the Services

Captain M. R. Mullins, S.A.M.C. Died in Italy.

Awards

NEW YEAR HONOURS.

C.B.E. (Civil Division).

T. B. Johnston, M.D.

O.B.E. (Military Division).

Acting Wing-Cmdr. R. W. B. Ellis, R.A.F.V.R.

O.B.E. (Civil Division).

Lieut.-Col. K. S. Fitch, I.M.S., Deputy Surgeon-General, Famine Relief, Bengal.

M.B.E. (Military Division).

Temp. Surg.-Lieut. M. J. May, R.N.V.R.
Captain (temp. Major) D. J. Wigginton, R.A.M.C., T.A.

The following awards have been made in recognition of gallant and distinguished services in Italy :—

O.B.E. (Military Division).

Major (temp. Lieut.-Col.) F. G. Holman, R.A.M.C.

M.B.E. (Military Division).

Captain (temp. Major) I. A. MacDougall, R.A.M.C.
Captain W. L. Ogle, R.A.M.C.
Captain F. E. Pitt-Payne, R.A.M.C.

Births

BROCKLEBANK.—On January 5th, 1945, at Salisbury, to Winifred, wife of Major J. A. Brocklebank, R.A.M.C.—a daughter.

Marriages

CRISP—JAQUES.—On January 13th, 1945, at Southwark Cathedral, Paul C. J. Crisp, L.D.S., R.C.S. (Eng.), to Betty E. Jaques.

Deaths

AYLEN.—On December 15th, 1944, George Herbert Aylen, L.D.S., R.C.S., of Victoria Road, Southsea, Hants.

CARR.—On January 6th, 1945, at 5, Crescent Road, Bournemouth, Thomas Gray Carr, M.R.C.S., L.R.C.P.

PARROTT.—On January 14th, 1945, at the Royal Isle of Wight County Hospital, after a brief illness, Arthur William Parrott, L.D.S., R.C.S. (Eng.), of "Keynsham," Sandown, Isle of Wight (Guy's 1902–5).

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1475 *3rd February, 1945* *Ninepence*

PASSIM

PERHAPS the medical student is a parasite on the patient from whom he learns; perhaps the latter would prosper as well, or even better, without the attentions of the former. Assuredly the patient need gain nothing from the relationship. The clinical value of a new ward clerk's physical examinations is doubtful; the satisfaction that frequently repeated history-takings may afford the hypochondriac is no gain. How then may the patient profit? He may at worst, gain nothing better or more personal than the knowledge that his submission to tiresome examinations is a public spirited act; but not every patient can easily appreciate himself in this role. Many of the inmates of voluntary teaching hospitals merely tolerate this interference, regarding it as all the payment they can make in return for the medical treatment they receive. Many patients too, mistake a student's zeal for learning, for a "young doctor's" routine examination; and we know one ward sister who used to help in the deception in the case of reluctant patients by the ingenious process of "promoting" student to the office of houseman and houseman to the rank of specialist.

How may patients lose by their enforced relationships with students? Students' history-taking may expose them to tiring interviews and to tactless questions or indiscreet answers. One careless remark may sow the seed of syphilophobia or carcinophobia or some other dread; while another may nourish the growth of a suspicion already present. The discomforts of inexpert examination with its monotonous chest-thumping, its unnecessary repetition of painful and even dangerous manipulations, and its torture of bungled venepuncture, are easily imagined.

Those who live in the Borough cannot help noticing, sometimes with embarrassment, the respect with which medical students are in some quarters regarded. This respect is in most cases so inexplicable that one must think that it is founded on gratitude to the Hospital as much as on ignorance of the true nature of the students. Ignorance too, may be the foundation of the disrespect shown by a student when he thinks of his patient just as "the nephritis in No. 11 bed" and as a diseased organism rather than as a potentially healthy human being.

Much has been rightly written and much rightly spoken of the social aspect of medicine; but it is easy to regard it as a vast shapeless subject, chiefly a matter for parliamentary debate. The student however, may make for himself the discovery of its importance in the wards, and may bring his knowledge of the social affairs and occupation of the patient to play in the diagnosis of the case. By diligent history-taking and examination the student may happen on a significant piece of information missed by his seniors; and at first at any rate, he is more likely to make such a discovery in the field of social medicine than in a purely clinical matter.

As Professor Ryle has emphasised, the subject whom the student treats as a patient rather than as a "case" will both gain more and give more.

AT one time students' contributions to the *Gazette* were not confined to an occasional letter; ward clerk's reports of singular and interesting cases quite frequently used to appear in print. This custom, which has fallen into disuse, seems worthy of revival. Therefore such contributions, whose general interest is sufficient, would be gladly received and as many of them as paper-rationing allows would be published.

WE must apologise for the printer's errors in the last edition of the *Gazette*. Occurring as they did in Mr. T. B. Layton's review of *Sound in the Sky and Other Poems* by David

Stafford-Clark, they undermined both the sense of the reviewer's text and the sensibility of the poem. The last lines of this poem should read :—

"No present vision claims my eyes
But a clear thought, that asks not sight.
And your warm laughter that I once recalled
To answer grief, and still the agony of loss,
I need recall no more ; memory is transcended
By your true spirit's communion in my heart ;
Glowing and fresh that will not be denied."

While "Is it too high a praise to say there is in this a touch of Adonais ?" is, of course, Mr. Layton's comment.

On January 11th, 1945, a dance was held at which Mrs. Blaikley was kind hostess. Its object was the same as "The Resident's Play" of old—namely, to be a gesture of appreciation to the nursing staff for all the parties and dances at which the nurses had entertained students and residents over Christmas. The College restaurant was used as ball-room. It was probably the first time this room has been used for such an occasion; and most of the reasons why, became evident at an alarmingly short period before the dance was due to start. But with the aid of nearly every department of the Hospital and of the near suicidal feats of an electric wire laying gang, the evening was saved.

The profits of the dance are to be sent to the Red Cross to provide parcels for old Guy's men who are prisoners of war.

"Dare Quam Accipere"

A Clinical Lecture by T. B. LAYTON, D.S.O., M.S.

GENTLEMEN,—When we search into the hidden meaning of men's deeds we find in each of those of Thomas Guy something a little more than there is in those of most. In nothing that we know of him was this more evident than in his choice of a motto for his Hospital. I believe that in that we have a revealing item of autobiography. But while he was trying to carry into his daily tasks the teaching that it is more blessed to give than to receive, the conception of human life was very different from what it is to-day. It postulated that by the fact of their birth there were some who were above the rest and that this rest descended by varying degrees to what were called the lower classes, the *canaille*, the scum of humanity. These were there because they were everlastingly doomed to the position as a part of Nature. In the anatomical terminology of to-day, men's genes were different between the classes. Some had within their cells the hereditary genes of aristocracy and were entitled to a life of ease. It was permissible for them to perform with impunity deeds that would have given a stigma of original sin to the scum ; while these were doomed in the sweat of their faces to provide the motive power that could produce the needs of those that toiled not. Under such an hypothesis of human life there was no chance of raising the lower classes above their destined status ; but there were kind and good people who wanted to relieve the suffering of the poor. This was done by deeds aided by money ; but as time went on money took first place and deeds were relegated to the paid secretaries of charitable institutions. It is this charity that many worthy people have resented being compelled to receive of recent years. It is of this that a virile young lady politician spoke when, in a local brains trust, she said, in reference to a question on the Beveridge Report : "We want to get rid of the very smell of charity."

To-day we live under a different dispensation. It is one that believes that we are dedicated to the proposition that all men are created equal.

And so I want you to-day to consider how you can carry into your work at Guy's, and after you leave it, the principle of our founder under which you enrolled when you joined us. The problem is how are we to carry out in our work as doctors under the

new dispensation that all men are created equal, the principle that it is more blessed to give than to receive? There is a tendency to-day to vaunt ourselves, not so much as Guy's men and women, but as members and representatives of the Voluntary Hospitals. This is a fake form of patriotism and to some extent may be condoned; but when it becomes marked it does harm to the very organisations which it seems to puff up, and carried to excess it becomes unseemly. There is a group of well-meaning and worthy persons who seem to believe that all work done at the Voluntary Hospitals is of the first rate; that by the mere fact of its being done there it is better than it would have been had it been done in a municipal hospital, and that all work done in these is doomed to be second rate. I will not admit the truth of any of these three hypotheses. I resent most bitterly the imputation that the little children upon whom I have operated by the hundred in the municipal hospitals have been less well cared for by myself, by medical officers, or by the nursing staff than have the much smaller number who have been under my care here. And so I would ask you not to thank your God you are not as other men, condemned to an inferiority of labour. There is no aristocracy of medicine. There is room for improvement—always, everywhere. Lane once said to me: "You must always have an ideal; but you must never attain to it, for when you find yourself doing so you must put it further away." But the mere fact that you were trained at Guy's and did your clinical medicine in the wards of a Voluntary Hospital is no guarantee that you are raising the standard, always, everywhere.

Only one or two of you will remain or return here for your life's work and when you go elsewhere and see work which is undoubtedly inferior, but which all around accept as right, do not at once go telling them what you did at Guy's; think first whether there was anything done here and accepted by all as good, which hit the outsider's eye as being bad. Then and not till then you are in a position to try to improve that which is poor where you are, to correct that which is wrong. It is not the institution that you found when you entered it that matters; it is the one you leave. English medicine will be raised throughout the Empire by doing good work and by this alone, not by exalting one group of institutions.

And the next way in which I would ask you to try to carry out the principle that it is more blessed to give than to receive is by paying a minute attention to detail. Lane once said to me that he had never known a death under anæsthesia that was not due to carelessness or to inexperience, and usually to both. I did not, even then, like his use of the word "carelessness," but substitute for it "want of attention to minute detail"—and my experience is as his. Remember that death under anæsthesia is not the only tragedy in all medicine. It is a blatantly irrecoverable one. In all others either you have the processes of Nature irretrievably against you, or, by their healing powers, they mask the results of your want of attention to detail. There is no better example of this principle in the whole of medicine than the treatment of discharging ears in children. Once we have decided there is no immediate danger to life we are inclined to let things slide. But there is that other risk to life that arises from chronic disease, and you are responsible for that death if you have refrained from doing some minute detail during the acute stage of the disease. Mind you, it may be very boring. Day after day to try to teach young women how to make a twiddle of wool with which efficiently to mop an ear, week after week to remove those little bits of wet epithelium against the drum-head that they have been unable to get up, but which prevent the final healing. These require the greatest perseverance. Great operations can only be done by a meticulous care and attention. If these are not forthcoming the mortality becomes so high that the operation dies a natural death. The same care is needed in the lesser surgical procedures to prevent morbidity. This leads to early death later; but we have hardly entered into the stage of surgery where the prevention of morbidity is considered as important as mortality. In this the obstetricians have given us a lead. If we consider humanity as well as the human being, as much benefit will ensue to it by the prevention of morbidity by small measures as by salvage from death by great ones. They must be done by all—by care and by attention to detail. There is no limelight in it. The light that is needed is that enthusiasm for humanity which changes work from being a feeble restraining power to an inspiring passion.

Please remember that this applies to medicine as well as to surgery. The coming of the new drugs has produced just as great a revolution in the former as antiseptics did in the latter. Their application and administration need as great an attention to detail as does the running of a modern operating theatre; but with their coming there is a tendency for the older medicine to be forgotten just as has been the older surgery. The preparations of opium and the purgatives are weapons to be used, not

to be thrown about, and their use implies a minute attention to detail and constant practice. You do not make a man a fencer by putting a rapier into his hand. You do not make a student a doctor by handing him a diploma. These drugs afford instances of a great deterioration in medicine compared with that of my youth. Doctors cannot use these two groups in a way their predecessors did. You must give thought, observation and attention of your own to them, and not merely receive reports from nurses.

The next way in which you can give more than you receive is to start work early. If you do this no one can catch you up during the day. Do not think I find it easy to be early. Though I wake early I find it just as hard to get out of bed as you do; and I am very fond of dawdling when I have done so. It is not from ease that I have tried for over twenty years to get my dressers to attend at 9 a.m. on Monday morning. It is because I think work in all hospitals should start at that time, and that doctors should be in their wards by 9.30 a.m. In this we are deplorably behind other countries. But it is not only that. The view is put around by your teachers and the organisers of your work that the medical student is a delicate little darling that cannot arrive before 9.30 a.m. or even 10 a.m. I will believe that these teachers are sincere when they themselves turn up at 9 a.m. and spend that half-hour in doing all the little oddments that service to a great hospital demands; but I will not believe even then that they are right. I lived in the City in the great "blitz" and I heard your sisters tramping to their work, scrunching the broken glass in the dark; and then was told our students could not do the same. What is the use of your football and your other games if you are to be pampered by your teachers into little milk-sops thus? At other hospitals I know that lectures are still given at 9 a.m. and I know they get a theatre full.

Go then through your week's work and think how in everything you do you can give more than you receive. A smile to a child, a pat on the shoulder to the mother to give that little extra confidence that will help the medicine you order. Encouragement to the young to remain at work, a chosen word to convince those in middle age they have no dread disease. A shift of your position so that you can get the best out of your hands in their examination, a refusal to start that examination until the accommodation at your disposal is placed to the best advantage.

You may say that these are all small things in which I have been failing all my life. What right have I to come and preach to you? It is because I have failed that I have that right. I should have failed constantly in all these things even if I had known early of their importance. But I might have done so less often if it were not that between the wars we worshipped false gods. We all wanted to be great, and we thought that money was an end. A world-wide reputation and a loaded banking account whereby to purchase it. And when we are dead we shall be forgotten utterly except in the hearts of those few people in South London to whom we were kind when we tended them. Set your minds on the little things and the little people. Chance the world-wide reputation. Live more fully in the hearts of men than my generation have done.

But life is not all giving and there is something you should receive at Guy's and that we did receive, pressed down and running over. That is the right—nay, the duty—to doubt everything your teacher tells you. There is to-day a sad setback in the way that this is meted out to you. There is so much to know that it has to be hammered in. Text-books take up too much of your time. Lectures have been chopped and replaced by innumerable tutorial classes which are crowded into the middle of the day so that students have to leave the wards and clinics before time, thus clipping still more their length already shortened by the late beginning. But chiefly is it the way you are taught. To sit around while a physician shuffles papers, or a surgeon examines the patient and, instead of compelling you to do the same, just talks. Thus are you reduced from the status of university students to that of goody-goody little schoolboys. But still there is your ancient heritage, not yet quite waned, of your right to doubt, a right that you can only claim by personal observation and independence of mind. Lane, who spoke badly, though he could spin words into golden webs that will last the ages, once said to me: "If ever there is anything in surgery on which everyone is agreed it is almost certain to be wrong." I have found that to be true. If you go out into the world with this spirit within you, you will have received from Guy's something that will compel you to give much in order to attain to the blessedness of "*Dare Quam Accipere.*"

Obituary

CAPTAIN MICHAEL ROBERT MULLINS, B.A., B.M., B.Ch. (Oxon.), S.A.M.C.

THE news of the tragic death of "Mike" Mullins from pneumonia, contracted whilst on active service in Italy, came as a great shock to his many friends at Guy's.

A member of a well-known South African family of Guy's men, "Mike" came to Guy's from Trinity College, Oxford, at the outbreak of war in 1939. He at once established himself with contemporaries and seniors alike as one of the most popular figures in the Hospital. Good at his work, outstanding at sport, and possessed of all the qualities most valued among men, the reasons for his popularity were not far to seek. As a student his diligence, ability and loyalty made him an ideal ward clerk and dresser; and his unfailing cheeriness, good humour and sportsmanship made him an indispensible member of all gatherings. The honour and pleasure of being associated with him both at work and play will be a prized remembrance of all his friends.

Born with football in his blood, Mullins entered Guy's as a regular member of the Oxford University XV; an unfortunate injury had prevented him playing in the all-important 'Varsity match in 1939, the last year before the War in which "Blues" were awarded. He played his first game for Guy's in October, 1939, and continued to play regularly for four years. He became honorary secretary in 1940–41 and received the coveted honour of captaincy in 1941–42, thus following faithfully in the footsteps of his father (R. C.), who was captain from 1898–1900, and of his uncle (H. R.), who led the side in 1909–10. The family tradition was further maintained by his playng for the Barbarians for two years in succession. He was also captain of the United Hospitals and of a representative London R.U. XV. In peace-time international honours might easily have come his way.

"Mike" will be remembered for many things on the football field. As captain he was an inspiring leader and of immense value as a team-builder, and during his year of office the Guy's XV had its most successful war-time season. Individually he was an outstanding wing forward and place-kicker; in all he played sixty-nine games for Guy's, scoring 8 tries, 32 penalty goals and 61 placed goals. To single out any particular performance from such a brilliant career is almost invidious, but undoubtedly he played the game of his life against the powerful St. Mary's side at Honor Oak Park in 1942. This will always be known as "Mullins' match" by Guy's men, for he completely and successfully "shadowed" the notorious Tommy Kemp and prevented that star international ever getting his three-quarters moving. Kemp tried every trick he knew, but Mullins was always a move ahead, and in the end he kicked a penalty goal to give Guy's a 10–6 win in a thrilling game.

Mullins qualified B.M., B.Ch. (Oxon.) in June, 1942. He was then appointed house-officer in the E.M.S. and served at the County Hospital, Pembury, as house-physician to Dr. Osman and Dr. Jacoby, and as resident obstetrician to Mr. Chapple until January, 1943. At Pembury his popularity was as great as at Guy's and his success as a house-officer was evident to all with whom he worked. In 1942 he married Doreen Levy and, on completion of house appointments, he returned with his wife to South Africa in February, 1943. He was one of the first South Africans from Guy's so to return, and that he should do so at the height of U-boat warfare in order to join the Services of his mother country is typical of his courage and sense of duty. Shortly after being granted a commission in the S.A.M.C. he volunteered for service abroad

and, under the rigorous conditions of an Italian winter, met his untimely death. Our sympathy goes out to his wife and infant son, and to his mother, in the tragedy of their irreparable loss. S. H. W.

AN APPRECIATION.

ALL of us at Guy's who knew M. R. Mullins have heard of his death on active service with very great regret. This is no stereotyped phrase, he was too sincere a man for that. I well remember the first day I saw him; it was obvious who he was—here was a man.

Later he was a dresser of mine and then became my resident officer at Pembury. He was one of that band of all-rounders of Guy's men that have made the name of Guy's stand high. He was not only a great athlete, but a great personality. He sought favours from no one, he had no need to, they were offered to him. For our part then, we offer our sincerest condolences to his people and his widow. It may help them in their sorrow to know that Guy's feels it is the poorer for the loss of him. Would that we had many more like him! H. C.

Reviews

Varicose Veins, Hæmorrhoids and Other Conditions; Their Treatment by Injection. By R. ROWDEN FOOTE, M.R.C.S., L.R.C.P., D.R.C.O.G. Published by H. K. Lewis & Co., Ltd. Demy 8vo. Pp. viii+128. Fifty-four Illustrations (some coloured). *Price* 12*s.* 6*d. net.*

THIS small volume deals with the modern treatment of varicose veins and covers all the recent literature on the subject. The author obviously pays a great deal of attention to detail. He discusses the position of the leg during the injection and the technique of puncturing the vein. This procedure is well illustrated and many could study it with profit.

The section on the operative treatment is written by Mr. Rodney Maingot. He describes the usual operation done under general anæsthesia; his impression, shared by many, is that "these small transverse incisions placed high up in the thigh close to the genitalia heal more kindly when local anæsthetics are not employed."

The book concludes with the injection therapy of hæmorrhoids, hydroceles and ganglia. Injection treatment of inguinal hernia is mentioned, to be condemned. F. R. K.

Pye's Surgical Handicraft. Edited by HAMILTON BAILEY, F.R.C.S. Fourteenth edition. Bristol: John Wright & Sons, Ltd. 1944. Pp. 628. 724 Illustrations. *Price* 25*s.*

THIS fourteenth edition of *Pye's Surgical Handicraft* well preserves the traditional high standard that has been the feature of the work since its inception in Lister's day. In keeping with the principles that he enunciates in his preface, Mr. Hamilton Bailey has stressed the value of pictorial teaching by adding some two hundred further illustrations to this edition, many in glorious technicolour. The whole work is comprehensive of surgical procedures outside the field of major operations and even encroaches on the physician's ground by describing some medical procedures. The chapters on the treatment of fractures by Mr. R. Watson Jones are concise and excellent, while the latest views on burn treatment are all submitted and their relative merits discussed.

To list the many outstanding qualities of this book would take more paper than there is to spare; sufficient to say that no houseman nor senior dresser should be without it. J. D. L. R.

A Guide to Anatomy. By E. D. EWART. Published by H. K. Lewis & Co., Ltd.

THE knowledge of anatomy expected of the present-day students of physiotherapy ranges over much more extensive ground than it did a few years back.

A Guide to Anatomy, though well set out and containing useful diagrams, is too condensed to meet the requirements of the anatomy syllabus to-day. The chapters relating to blood-vessels, nerves and viscera, in particular, fall far short of the information required. S. M. E.

Industrial Medicine. Edited by SIR HUMPHRY ROLLESTON, Bt., G.C.V.O., K.O.B., M.D., F.R.C.P.; and ALAN A. MONCRIEFF, M.D., F.R.C.P. With an Introduction by Air Vice-Marshal Sir David Munro, K.C.B., C.I.E., M.B., Ch.B., F.R.C.S. (Ed.), LL.D. The Practitioner Handbooks. Published on behalf of *The Practitioner* by Eyre and Sportiswoode (Publishers), Ltd., W.C.2. 1944. *Price* 16*s.*

THIS is a short book, well printed and nicely bound, but if the student hopes that the subject of industrial medicine is covered by it, he will be disappointed. Certain aspects are dealt with exhaustively. There's a whole chapter devoted to malingering, for example. Malingering is known in the forces, in prisons and very rarely in war-time industry, but in peace-time industry hardly at all. There is a chapter too, on backstrain and miners' nystagmus, both of which could well have been omitted for matter of greater practical value to someone engaged in promoting the *health* of workers, which is the essential aim for a good practitioner of industrial medicine.

There's an excellent chapter on industrial dermatoses, and two other good ones are those on ventilation and heating and lighting problems. A number of others, however, have a lecture-room unreality about them. A. J. Amor on chest disease, for example, says "the control of dusty atmospheres depends upon determining the number of dust particles present in the atmosphere." Needless to say, one may count dust particles until the grave claims the sufferer from silicosis, but that in no way controls the dust. He says not a word about exhaust ventilation or cleanliness or the various methods of dust-laying or disinfection of the atmosphere. The book is poor value for the price.

T. O. G.

Correspondence

REBUILDING OF GUY'S HOSPITAL.

To the Editor of the GAZETTE.

SIR,—The plan for the rebuilding of Guy's must have met with the satisfaction of of all with regard to the size and architecture of the proposed building. What the impressive picture fails to show is the surroundings in which Guy's is situated.

The beauty of the picture would have been considerably marred if the artist had extended his picture to show London Bridge, the Borough Market and Barclay Perkins brewery, each revolting the air with their noises and rendering it foul for human consumption by smoke and odours.

The tradition of Guy's will not die if we are moved into a new building, nor will it die if the main part of the Hospital is moved into an atmosphere more congenial to the patients' benefit. If we are to maintain the standards of rehabilitation set by His Majesty's Armed Forces, we must encourage our patients to use their newly-healed chests and limbs in fresh air and open places such as the Borough has never known.

At Guy's there must be full out-patients' departments and facilities for treating emergency cases, but do not let us be landed the "white elephant" which will result in the rebuilding of Guy's under the present plan.

Yours, etc.,

G. I. TEWFIK.

13, Ondine Road,
East Dulwich, S.E.15.

LIGHTING OF GORDON MUSEUM.

To the Editor of the GAZETTE.

SIR,—I was interested in Mr. W. E. Evans's letter in the *Gazette* of January 6th, 1945, and whilst agreeing with him on many points, I would like to inform him that one of the chief difficulties is that the current for lighting the Gordon Museum is not the standard 230-volt A.C., but 110-volt D.C., generated on the premises.

This voltage varies a great deal, and I have taken readings showing that the voltage has dropped at times to 90. This is 81.8 per cent. of the 110 voltage, which gives approximately 50 per cent. of the normal light output.

If, however, a 230-volt supply were installed, together with the Tubular Lamps which Mr. Evans suggests, this would be a great improvement, inasmuch as a 1 per cent. voltage drop in Tubular Lighting would mean only a 1 per cent. light output drop compared with a 4 per cent. output drop with the ordinary gas-filled lamp.

I should also like to point out that it is not suitable to instal fluorescent Tubular Lighting on direct current.

Yours, etc.,

E. G. SMITH.

Medical School Workshop,
Guy's Hospital, S.E.1.

OBSTETRICS IN ENGLISH AND IRISH SCHOOLS.

To the Editor of the GAZETTE.

SIR,—It is not within my power to contribute anything of value from a professional standpoint in a comparison of the obstetrics of the English and Irish schools, but a few remarks about the month which some of us spent at the Rotunda recently may be of interest.

It was stimulating to encounter a different point of view and different methods, particularly when one is in danger of developing the "examination" mind with its neatly (?) classified ideas. We all had to start from the beginning again and learn a different method of normal delivery. I personally found that it was possible to obtain better flexion of the head by the Rotunda method than by the English method. Delivery is carried out in the left lateral position with the operator's left arm placed around the patient's upper leg, so that the head is flexed by the pressure of the heel of the left hand on the occiput and assisted by pressure with the right hand on the fœtal chin, which is palpated between anus and coccyx. The grip on the chin seems to give more control over the movements of the fœtal head.

The third stage of labour was conducted on the side too. This made it more difficult to be certain the uterus was contracting down.

The experience on the district was first rate. Students were sent out in threes or fours (a fact which minimised the number of deliveries carried out, but not the experience of diagnosis and treatment) without a nurse or midwife, in rotation as the calls came in. It makes one think for oneself to be confronted by a case one has never seen before, without any antenatal notes and to have to diagnose it and decide whether or not labour is progressing normally, taking the responsibility of calling in assistance in abnormal cases. Clinical pictures seen like this are stamped on one's memory far more permanently than by an hour over a text-book. Obstructed labour, unlikely to occur in hospital, we saw prior to admission, and are unlikely to forget Bandl's ring or the maternal distress.

One has to manage with a minimum of equipment, and often under adverse conditions. No sterilised kit is provided and one has to take one's own instruments and boil them up as best one may. And there is no midwife to do the clearing up! It is an education in itself to come into contact with the people and see how some of them live. A man and wife with eight children living on 27*s*. 6*d*. a week is commonplace, and the cost of living is high.

There is a very large turnover of patients in the hospital and a large antenatal clinic every evening gives one plenty of opportunity for practice in diagnosis. This means, too, that one sees a large number of abnormal cases and instrumental deliveries.

There are other points of interest too numerous to mention; to see such appalling poverty amongst people with families of fourteen or fifteen brings one up against the problem of control of the birth-rate and its relation to the religion of the people; in the hospital we got some idea of what co-education in medical schools would be like. All students were resident during their stay; the men had bedrooms on one floor, the women on the next, and common rooms and mess were shared. It seemed to work all right.

Time forbids to tell of other things of interest in a neutral city. Of bright lights, of ham and eggs, of stately Georgian houses, now filthy tenements, barefooted children, and of the local district "fauna." (We all developed parasitosis of the common flea, though pediculosis corporis was only identified once and then his existence terminated rapidly); of the Wicklow Hills, snowcapped against a clear December sky, "white horses" and cormorants off the point at Howth, and the deep, black peaty water of inland lochs. All these things too, and not least, the kind hospitality of our Irish hosts, the Master, staff and students at the Rotunda made that stay of great value and not to be forgotten.

If this letter can serve to provide with information any who may be thinking of spending a month or more studying obstetrics in Dublin, it will have served its purpose.

On behalf of my colleagues and myself,

I am,

Yours, etc.,

RICHARD NEVE.

Guy's Hospital, S.E.1.

LETTER FROM FT./LT. H. B. O. CARDEW.

To the Editor of the GAZETTE.

SIR,—Your number of May 27th, 1944, has just reached me and I read with interest your comments in "Passim" on the profession's reactions to the White Paper—*with interest, but scarcely with surprise.*

I remember some years before the War there was a great "bind" at Guy's regarding our students' college across the way. It was general. Why could not something be done to provide the students with better conditions? As the editor of the *Gazette* I determined to champion their cause and prepared a questionnaire to find out what they really wanted. Here was an issue which immediately affected their lives. The response? If I remember rightly about 25 per cent. were dragooned into filling in the form. The attitude? Slightly superior, half amused contempt mixed with a trace of embarrassment. Well, of course, the whole matter was dropped, fizzled out and was very conveniently solved by Hitler some years later.

Now, what of the White Paper? This will not be dropped, nor can we rely upon disordered providence to solve our difficulties for us. The Government will pass some sort of a bill, and it is fair to predict that it will be a haphazard compromise of the White Paper and of the B.M.A.'s official rejoinder.

"What do I really want anyhow?" you quite rightly ask, but come up slap against the Englishman's inherent distrust of analysis to first principles. Socialisation of life is being forced upon an unwilling country—not by a group of theorising intellectuals, as some would suggest, but by the inescapable logic of events, and the poor old medical profession, comprising, perhaps, the largest collection of individualists in the State has been selected as the first victim. Let us accept that honour and make sure that we will achieve something really worth while.

Now to the Government's proposals. The impression made on me by a study of the White Paper and of the B.M.A.'s "provisional" attitude is that both are trying to make the best of two worlds. Each tries to reassure, on the one hand, the snobbish *bourgeoisie* section of the "patient" community and the reactionary elements within the profession, while satisfying on the other, the general demand for a scientific ordering of our resources (including man-power). They are both basically ingenuous documents, the principles enunciated in each cannot be achieved by the measures proposed. I can point out two major fallacies which underlie the proposals contained in the White Paper. Firstly, the application of the scheme necessitates a large increase in the number of doctors. Without the increase one is merely redistributing the labours and the income within the profession, and it cannot be maintained that any large increase of health would accrue to the community. I imagine that at least 10,000 extra doctors would be required. How and when are these to be provided? In order to *maintain* the number at its present level about 1,000 new doctors must qualify each year, and it is all that our present medical educational system can do to cope with these. If by some miracle of organisation the number could be *immediately* doubled it would still

take sixteen years before the necessary increase was obtained. Will a much impoverished property-owning class be in a position to pay for the six years' training necessary with a smaller financial gain to look forward to ?

Secondly, a vast building programme will be needed to build the new health centres and to replace the blitzed hospitals. Homes for the population are bound to take precedence, and quite rightly, for otherwise the general health of the country would actually deteriorate instead of bettering itself.

Once the Bill is passed there will be an *immediate* obligation to provide the total service. The absurdity is evident.

What is needed is a programme over, say, twenty years with well-established stages to be achieved at spaced intervals.

Lastly, a few words regarding the question of private practice within the scheme. This, I maintain, Sir, is an immoral compromise which will bring discredit upon the profession, for if the comprehensive health scheme is to provide the best of everything as promised, how will the private practitioner be able to seduce his patients from it except by dishonesty or by pandering to their ignorance and prejudices.

But, of course, the inner contradictions of the White Paper are only to be expected in a dying world which still clings pathetically to the belief that the scientific conception of the State is compatible with the jungle law. This confusion of mind may be permissible among politicians ; it is not in our profession with its scientific background and a tradition of service that goes back for two thousand years.

There is only one answer. Forward—not haphazardly and regretfully, but with deliberation of mind and heart.

Yours, etc.,

BRUCE CARDEW.

INTERNATIONAL STUDENT RELATIONSHIP.

To the Editor of the GAZETTE.

SIR,—I see in your columns that many eminent persons in this Medical School are at present concerned with the matter of international student relations and affairs, in particular with regard to the advice of that much-quoted medical philosopher Osler—" Young man, go abroad."

In this connection might I point out that the British Medical Student's Association (to which every student in this Hospital automatically belongs) has this matter high up on its programme ? The international secretary has worked on this matter for the last six months, and has now established many valuable contacts in other countries. Many of these students, including Indian, New Zealand and French, have expressed a wish that, at the resumption of peace, a scheme might be implemented for the exchange of students between university and university, country and country.

In order that students of the British Isles may derive some of the benefits of foreign contacts, the B.M.S.A. have formulated plans for inter-university visits. The medical students at Manchester have already taken advantage of this scheme, for about two hundred of them were invited to the University of Liverpool, and spent a profitable three days attending classes and demonstrations given them by notable Liverpool physicians and surgeons.

In the University of London, a scheme has been prepared and was due to start at the beginning of next month. Owing, however, to the poor response obtained from most of the hospitals, it has had to be delayed for the time being.

In so far as this scheme is to act as an antidote to the present insularity of our hospitals and medical schools, I feel that I might reasonably bring it to your notice.

Yours etc.,

R. D. WALSH

(General Secretary, B.M.S.A.)

Guy's Hospital, S.E.1.

Starlets No. 6

TOM HILLS has done it again, or in the terminology of Nuffield House, "The old file has had a cut and forced home with honours." This sixth edition of the Starlets' Revue was possibly more polished in its wit than any of its predecessors and, though it had its weaknesses, we found it excellent entertainment. For individual performance the honours undoubtedly go to Sid Hilton, who is a born comedian; his acting in this revue was worthy of the professional stage and it seems a pity that his talent is not allowed wider scope. Few will forget his impersonation of the Radio Doctor, which was as delicate a bit of playing as we have seen anywhere—it would have been so easy to overact the part and labour the humour, but Sid fell into none of these errors and provided what was probably the wittiest piece of the evening; incidentally, the author deserves the highest merit. Second only to this was that delightful sketch, "The Victorians," with Sid Hilton as the reedy tenor, Duggie Saunders the apoplectic trumpet-player and Barbara Wickham at the piano. Sid's voice, vying with Duggie's trumpet, managed to rise above the laughter of the audience and at the end of the song, everyone was in a state bordering on collapse.

The melodrama, "Little Nell," aroused the most violent emotions in us all. We wept with the aged old couple whose cottage was mortgaged to the local squire and villain (Sid), who earned many boos and catcalls from us. The heroine, admirably played by Beryl Moore, moistened many a manly eye that night; and the hero (John Blundell) gave a fine performance of daring and devotion, which was ultimately rewarded by the attainment of his heart's desire and the confusion of the villain, who died amidst a chorus of abuse. This sketch might have benefited by a more enthusiastic audience and possibly by being an act shorter; The Welsh chorus of the three Druids was pure inspiration.

A sketch which I enjoyed as much as any was Mr. Wass's "Switchboard," a remarkably true rendering of the personnel in Nuffield House; John Blundell's impersonation of Matron was embarrassingly apt in certain particulars.

To run through a catechism of all that was good in this show would be both tedious and unnecessary. But in passing, one must mention Irene Hales's songs—This little lady who, unfortunately mislaid her frock in the last revue, appeared fully and charmingly clad this time and gave us several of her ingenuous little songs. Others who deserve special mention are Godfrey Wotton, who was such a clever "Psychologist"; Margo, who danced for us and gave an instructive little talk on the radio; Peter Bryant, who told of conditions in the Nurses' Home; and Jean Jenkins who gave a very fine all-round performance.

Lastly we must doff our hats to Tom Hills, the producer, actor, playwright and composer, whose energy and drive made the show go so smoothly under many adverse conditions.

Oh, and we would like to know the name of the third from the right in the front row of the "can-can."

ANON.

Sport

Boxing

INTER-HOSPITAL COMPETITION PRELIMINARIES.

These were held on Wednesday, January 24th, 1945, in the Pavy Gymnasium, Guy's, under the jurisdiction of the A.B.A., whose officials included Harry Mallin, twice Olympic middle-weight champion.

Two Guy's men boxed in these bouts. In the 10st. 7lb—11 st. class M. P. O'Reilly fought Rizler, the Mary's captain. The fight was stopped in the second round in Rizler's favour, but O'Reilly has no cause to be displeased with his performance against an opponent who, though not a good boxer, is very strong and has had considerable experience of competitive boxing. In fact, Rizler "went to the boards" once in the first round.

N. H. Porter, in the 11 st.—11 st. 7 lb. class, beat his St. Mary's opponent, to enter the semi-finals. Porter was much the more aggressive throughout the three rounds and fully deserved the points decision. He would be well advised to "cover up" rather more, when he attacks.

The Guy's men who enter the semi-finals are:—

R. L. Leader and M. Mason (8st. 7lb.—9 st.).
J. M. Pugh (9 st. 7lb.—10 st.).
S. F. A. Westgate (10 st.—10 st. 7 lb.).
J. F. Shaw and N. H. Porter (11 st.—11st. 7 lb.).
C. H. Kinder (11 st. 7 lb.—12 st.).
M. W. Harber (heavy weight).

The Semi-Finals and Finals are to be held on Wednesday, February 14th, 1945, at 6 p.m., at No. 61 Arch, Tooley Street, S.E.1.

J. M. P.

Hospital Information, etc.

RETURNED FROM H.M. FORCES.

W. N. Whamond ("Bill") has just returned to Guy's to complete his medical studies after serving four years in the R.A.F. as a bomber pilot. He started his medical course in October, 1938, but left to join the R.A.F. in 1940, where he gained the D.F.C. and Bar.

Pass List

UNIVERSITY OF LONDON.

THIRD (B,D.S.) EXAMINATION IN DENTAL SURGERY.

December, 1944.

Pass.

S. G. Le S. Beaton — A. Ferrari
A. J. Brunnen — B. H. De C. Prideaux
A. C. Campbell — D. H. Norman

Supplementary Pass List.

The following Student has passed in Group II:—

G. A. Morrant

SECOND EXAMINATION IN DENTAL SURGERY.

PART I.

December, 1944.

H. M. Hughes — D. G. Jones

The following Students are credited with Anatomy and Physiology:—

J. C. Farrow — R. L. Leader
C. N. Furnivall — L. G. Richards

PART II.

R. A. Morsman

UNIVERSITY OF CAMBRIDGE.

December, 1944.

PART I.—Final M.B.

Surgery, Midwifery and Gynæcology.

J. P. M. Bensted — T. C. L. Parry
R. A. Green — M. G. Thorne
P. R. A. May

PART II.

Principles and Practice of Physic, Pathology and Pharmacology.

I. S. Hodgson-Jones — J. M. Thomas
P. R. A. May — D. P. Wheatley
M. W. L. Mutch

Papers by Guy's Men

Forbes, J. R. Bismuth Therapy in Jaundice during Antisyphilitic Treatment. *Brit. Med. J.*, 1944, ii, 852.

Muntarbhorn, S. Cavernous Sinus Thrombosis treated with Penicillin, *Lancet*, 1945, i, 10.

Camps, F. E. The Ætiology of Puerperal Sepsis. *Med. Pr.*, 1944, 212, 409.

Layton, T. B. The So-Called Typical Adenoid Facies. *Clin. J.*, 1945, 74, 1.

Smith, R. E. The Value of Simple Research in Public School Medicine. *Clin. J.*, 1945, 74, 10.

Braithwaite, J. Vernon. Disorders in Childhood. *Post-Grad. Med. J.*, 1944, 20, 350.

Mutch, N., and Another. Inhalation of Chemotherapeutic Substances. *Lancet*, 1944. ii, 775.

Mitman, Maurice, Aerial Infection. *Brit. Med. J.*, 1945, i, 71.

Change of Address

J. C. Bulstrode, Surg.-Lieut., R.N.V.R., H.M.S. *Courier*, c/o G.P.O.

J. B. Blaikley, F.R.C.S. Professional: 40, Devonshire Place, W.1 (Welbeck 7173) Private: 4, St. Thomas Street, S.E. (Hop 2225).

G. C. Denny, Surg.-Lieut., R.N.V.R., H.M.S. *Termagent*, c/o G.P.O.

H. H. Kenshole, Col., R.A.M.C., D.S.O., A.D.M.S. British Increment, H.Q. 5th Army C.M.F.

T. B. Layton, D.S.O., F.R.C.S., U.N.R.R.A., c/o A.C. Headquarters, Ministry of Co-operation Bldgs., Via Vittoria, Veneto Roma (tempy.).

J. W. Lee, Lt. D.C., U.S.N.R., Navy 524, c/c F.P.O., N.Y.C.

K. F. McAlpin, L.D.S., R.C.S., 36, Queen Anne Street, W.1 (Tel.: Langham 2987).

J. M. Robertson, Surg.-Lieut. Cmdr. R.N.V.R., H.M.S. *Ophir*, c/o G.P.O. London.

E. D. Stanhope, Major, A.D. Corps, c/o Glyn, Mills & Co., Whitehall, S.W.1.

New Year's Honours

O.B.E. (Military Division).

Surg. Lieut.-Comdr.(D.) C. D. Malone, R.N.V.R.

Awards

Mentioned in Dispatches.

The following Air Force medical officers have been mentioned in dispatches:—

Sqdr.-Ldr. P. M. Davies, Sqdr.-Ldr. A. T. M. Roberts, Actg. Sqdr.-Ldr. C. Bucknall, Actg.-Sqdr. Ldr., T. A. Hale-Monro, Actg.-Sqdr.-Ldr., W. L. James.

Casualty

Wounded.

Captain D. J. Tibbs, M.C., R.A.M.C.

Marriages

FIGGIS—HARGREAVES. — On January 27th, 1945, at R.C. Church, Harrow-on-the-Hill, Morton M. Figgis, Captain, R.A.M.C., to Jean Mary Hargreaves.

Deaths

BOOTH.—On January 20th, 1945, Edward Hargrave Booth, M.D., of 24, Pembroke Avenue, Hove, Sussex, aged eighty-eight years.

MULLINS.—On December 26th, 1944, on active service in Italy, Michael Robert Mullins, B.M., B.Ch.

PEDLEY.—On January 9th, 1945, Charles Franklin Pedley, B.A., M.R.C.S., Deputy Medical Officer of Health, Bournemouth.

STEEL.—As the result of enemy action, Maud Steel, Store Portress, at Guy's 1935 to 1945.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1476 *17th February, 1945* *Ninepence*

PASSIM

IT was reported in an evening paper a few weeks ago that an eminent woman, a Member of Parliament and a doctor, had said in the House that she looked forward to the day when such hospitals as Guy's and Bart.'s would be compelled to take women students. Whatever our own views are on this subject, it is a fact that, if a hospital wants to be eligible for the Government grants towards medical education under the regulations proposed by the Goodenough Committee, that hospital must take a percentage of women students. Many who object to the idea of medical co-education do so very often because of prejudice rather than from any well-formed ideas and arguments on the subject; we must admit that we are rather at fault in this way ourselves. We have, however, experienced the difficulties of medical co-education before coming to Guy's and consequently we feel that we are more justified in expressing an opinion than those who have not had this basis to work on; and it is those, who have not worked together with the fair sex, who are usually most insistent in their clamouring for the new order.

Let us make it quite clear from the start that we labour under no prejudice against women doctors; many branches of medicine are highly suitable for a woman to follow and, indeed, there are some in which women may be even more successful than men. The question, however, seems to resolve into, "Why should women be educated together with men?" rather than "Why shouldn't they?" Is there any urgent demand from the profession as a whole for this innovation? Does the fact that men and women doctors are largely educated separately influence their professional relations with each other in Practice?

It is only fair that women should have equal opportunities as men in their medical education; but, to ensure this, let bigger and better-equipped hospitals for women students be built and do not try to graft them unnaturally into the existing hospitals. We must emphasise on such a controversial subject that these opinions are purely our own, but representative opinion from the Hospital would be very valuable and we would encourage correspondence on the subject.

The above sentiments in no way detract from the warm welcome that we would like to extend to those students from the Royal Free Hospital who, owing to the exigencies of these times, are temporarily pursuing their pre-clinical studies at the Hospital.

OUTSIDE the Hospital to-day we cannot admit that we come from Guy's without provoking the inevitable question, "What has happened to Guy's rugger this year?" So far we have forborne from comment on this subject, but the *débacle* against Cambridge has at last provoked us to put the question ourselves, "What has happened to Guy's rugger?"

Many plausible explanations and excuses have been forwarded by our staunch supporters; but the matter ultimately resolves itself into two possibilities—either we lack the players or we lack the organisation, taken in its broadest sense, necessary to weld the players into a presentable team. It is difficult to believe that in a medical school as large as ours, we have not got fifteen men who can play good rugger, let alone first-class play; consequently we must reluctantly fall back on the second explanation—namely that the organisation is lacking. Organisation depends equally on the organisers and the organised—in our case, both seem to be at fault. The secretaries of the various rugger teams have written a letter on this subject to *Pulse*, and we are eagerly awaiting results.

In this issue we are publishing critiques of the two plays recently presented at Guy's and Farnborough respectively. These further indications of the revival of interest in social activities in the Hospital are most encouraging and we hope that Mr. Thomson's suggestion that the Dramatic Club should be put on a firmer basis is given due consideration.

Another festure this week has been an excellent gramophone recital under the auspices of D. Grant.

Southwark proved a great attraction on Saturday, February 10th, 1945, when both a performance of Handel's "Messiah" was given in the Cathedral and also the Tabard Players celebrated the birthday of Dickens with extracts from "Oliver Twist," performed in the yard of the "George." Shades of Dickens' Borough were awakened in the shape of Fagin and Oliver, the "Artful Dodger" and Bill Sykes, and a spirited performance was given by all the players; the two boys in the play came from the Lant Street school, which is near the lodgings where Dickens spent several years of his life.

We would like to express our sincere sympathy to Mr. and Mrs. J. H. E. Winston on the loss of their younger son in Holland.

The Index for Volume LVIII (1944) is now ready for distribution and may be obtained free of charge on application to The Manager, *Gazette* Office, Guy's Hospital, S.E.1; or at the Wills Library.

Clinical Acumen

By HUGH BARBER,

Consulting Physician, Derbyshire Royal Infirmary; Medical Registrar, Guy's Hospital, 1903–1905.

"*Please to remember this is talk; just as easy and just formal as I like to make it.*"—The Autocrat at the Breakfast Table.

When the troops came home from the South African War, one of the assistant physicians to Guy's Hospital came with them. Shortly afterwards the tip went out to a selected few that he would be doing a ward round, when he would see a case of typhoid fever. Met by his house-physician and his clerks, the band of seekers after truth had grown considerably by the time we reached the bed in question. The physician, thinking aloud as he examined the patient, ran through the history, the symptoms and the signs, more or less admitting that they filled the bill for a diagnosis of enteric fever; but then said, "I don't think it's typhoid," and passed on to the next bed. Back went the note-books to the pockets of the examination-passing students; up went the eyebrows of the house-physician, who had invited myself and other colleagues to such a sad fiasco, and those of us who were not concerned with the other patients tip-toed from the ward.

How many of us knew that we had received a first-class lesson in clinical acumen? For the event proved, of course, that the patient was not suffering from typhoid fever.

There is little profit in trying to define clinical acumen; it is easier to discuss whence it came. It grew. It came from the observation of the unaided senses. Medical knowledge can be gleaned from a book, and some of the arts of clinical observations in the wards can be taught; but the student who really learns is observing the physician to study his methods. It was just the same at cricket. A few maxims about a straight bat; keep the left elbow forward, and all that sort of thing; but the real lesson came from a visit to Lord's to watch a distinguished member of the medical profession, called "W. G.", make some runs.

Gull in 1872, wrote: "Example is contagious and descends from teacher to pupil." It was just this contagion for observation leading to clinical acumen, which we inherited when we listened to a wise physician thinking aloud at the bedside. It is recorded that Sir William Osler would not be told about the cases he was going to see, because he wished to start fair with an open mind, without any advantage over his students. This method sets a high standard of wisdom and humility. I remember a physician,

who adopted the plan, once saying that a ward-clerk was sometimes right; which, within the limits that the spoken word must fit with time and place, was a judicious and instructive remark. It puts the ward-clerk wise, that a diagnosis is not a guess, and that it takes years to gain clinical wisdom.

Professor Bauer, in *Constitution and Disease*, may write in 1943, "that all available tests and laboratory studies, invaluable as they may be, can never replace the impression gathered from an intelligent observation of the patient himself." This is up-to-date clinical wisdom; but looking back over these years, one cannot help feeling that the physicians in my undergraduate days had greater opportunities of gaining clinical acumen than we have to-day. John Brown, author of *Rab and His Friends*, speaks of the cultivation and concentration of the unassisted senses. It was an old maxim that the whole art of medicine lay in observation. The training of the unaided senses, that was the essential; and Gull had said that "the eye sees no more than it brings with it the power of seeing."

I suppose we should not cavil at the use of a simple instrument like a stethoscope. It had some struggle in its youth. There is a story that Dr. Cholmeley of Guy's Hospital was no great enthusiast for the instrument in the eighteen twenties; but one day brought a new one into the ward, where he placed in on a table and, inserting a flower, exclaimed: "What a capital bouquet holder!" It was Michael Finsbury, in *The Wrong Box*, who said there was nothing like a little judicious levity. No doubt Dr. Cholmeley wished to preach a sermon that the instrument does not make the physician; but it would have been more in season if he had shown some signs that he had tried to use it. Surely that is the approach to any instrumental aid; first perfect the technical use and then keep it in its place.

Of the unaided senses there is the story of Sir William Osler asking a clinical clerk about the first step to be taken at a particular bedside, to which several incorrect answers were forthcoming; so that the physician had to explain that the first step was to ask a doctor standing by the bed to remove his shadow from the patient. That was a cardinal point; observation in a good light; to find evidence, which possibly to-day may be sought for in a dark room by someone else.

I have known a good resident, in modern times, to be thinking of a barium meal for a patient with a history of hæmatemesis, when an abdominal examination revealed the probability of splenic aneæmia. I have seen one patient in hospital, who could tell me that he had been jaundiced for two days, but no one else knew this; although he was written up for various investigations.

I should say that pyloric obstruction requiring surgical relief can frequently be diagnosed by inspection; and alternatively, that after a radiological report of considerable delay in emptying of the stomach, clinical signs should be sought. Perhaps there is nothing very original in all this; but those of us who had to work without out modern advantages must take every opportunity of keeping alive the arts of observation. One hears it expressed sometimes that a student must remember that he will not always have hospital facilities at hand; but it should be more of a positive approach. If a special investigation in hospital has given some clear indication, let us go back to the bedside to see if this could have been foretold.

Our forefathers corrected the limitations of a physical examination by their knowledge of morbid anatomy. We have the advantage of radiology, which we can use at the bedside. It is interesting to find that the best radiologist requires the history and the associated symptoms. A physician must check some of his physical findings by means of an X-ray picture, but the converse is true, that some of the pictures must be interpreted in the light of what the unassisted senses can detect.

Many physicians, and Lister of the surgeons, had learned observation as naturalists. In the medical wards at Guy's in 1900 we always had three or four cases of typhoid fever. We used the Widal test (at that time four years old), but we did not rely upon it; I don't think it was perfected. We did not look for the bacillus in the stools; I don't think we knew there was a leucopenia. In doubtful cases, because recovery came, a distinguished physician might suggest that it must have been typhoid after all. One of the sisters taught me that one need not worry about the condition of the typhoid patient, who lay peacefully on his side, but it was not a good sign if he was taking much interest in life, as for example, buying a morning newspaper. These patients were the corner-stone of intelligent observations in the wards. We had to diagnose meningitis without the aid of lumbar puncture. I think we had more patients with acute rheumatic fever. Pneumococcal pneumonia was common; the course varied, but the clinical picture was characteristic and true to type.

To look back on one's own experience in arriving at the art of diagnosis is a little difficult. As a student or junior resident, there was little knowledge and few chances of exercising the faculties on new patients, who had not yet received a label. As a house-physician one could begin to sum up the history and the signs, weighing the evidence with the knowledge that guess-work was incompatible with the responsibilities of the office. Looking back, it seems almost providential that a superficial guess was almost always wrong. No one can state at what stage some clinical acumen has developed; because to claim this gift is probably an indication that it is wanting. Clinical acumen is like commonsense—it is for use and not for show.

The progress of medical science has changed the type of patient under observation, has tended to change the individual observer for a team, which possibly has no captain, or perhaps the members are not playing for the side. It would be ridiculous to deride improved methods of diagnosis or genuine aids to observation. The point to remember is, that using these may show greater detail but narrow the field of vision.

We as physicians to-day must set our own high standard; having read the history, there comes the observation of the unaided senses, with perhaps a stethoscope thrown in. By this time, in diagnosis, we ought to be getting there or thereabouts. If reports are already available from special departments, we must burn our boats and give some opinion before we read them. It is the only hope of gaining, or retaining, clinical wisdom. It may be a bit of a set-back to be ploughed as a candidate by one's house-physician with a report up his sleeve, but there comes the great day occasionally, when a second report is called in as a court of appeal and one's judgment is upheld. The personal side of the problem is a matter of temperament; are you a physician seeking for the truth or have you found it?

Most intriguing of all is the case for which all the special departments are called in, when one has dared to prophesy that not much help would come and in fact does not, but been able from past experience to give a reasonable outline of the course of the illness—the sort of case that illustrates Professor Bauer's contention, that it is bad practice to adhere too closely to the routine labels of disease. He writes of "modern laboratory medicine, which overlooks the patient behind the files of reported tests."

Clinical wisdom is still at its best when a good surgeon is studying the patient with an acute abdominal problem. Here is the great opportunity to exercise the unaided senses, to draw on past experience honestly interpreted, and perhaps to show two o'clock in the morning wisdom in addition.

By contrast we may remember, over a period of years, the exploratory laparotomy in chronic conditions with recurrent abdominal pain. Often enough the clinical condition was a spastic colon; partly causing and largely caused by nervous manifestations. It seemed so simple to look inside to find out what was making all this pother; and the event proved almost identical with the case of the small boy who took a penknife to his drum.

Preventive medicine has relieved us of former responsibilities; the old dictum that we do not treat the typhoid fever but the typhoid patient, is becoming more or less historical so far as the general medical wards are concerned. The beds, once occupied by typhoid fever cases, may be used for a succession of patients, admittted to facilitate some special investigation.

The Victorian physician spoke of disease plus patient. Of course we still have this problem, and more particularly we understand it in relation to what we now call psychosomatic medicine. Every new treatment, however, of a curative nature brings a new problem for clinical experience, which at first is confusing. We may begin by asking the older physicians whether the results are better; but in a disease like pneumonia the natural virulence varies in different years. Sydenham knew how fevers varied with the years. No doubt in many cases it was a question of virulence. We are so apt to get beginner's luck, whether we apply a new poultice called antiphlogistine (which I have seen written up in journals as a specific remedy) or use a vaccine or a new mixture of creosote and iodide.

When we do get a cure, however, the disease has several plus signs, and the patient a minus. This is true of standardised diphtheria treatment, or arsenobenzol for syphilis, and now perhaps for the sulphonamides in cerebrospinal fever and some other conditions. It is all very interesting. The knowledge which older physicians have gained about the natural history of any disease must be preserved, at least until such time as a new treatment has proved its worth beyond any shadow of doubt.

The seniors must give the new remedies an honest trial, but must have the courage to discard them without fear that they will be considered out of date, if the remedies do not prove their worth. My seniors could tell me that I did not know what diphtheria was really like. I am not quite sure what I can tell a house-physician about pneumonia at the present time. The natural history of the disease has changed, quite apart from so-called atypical or virus pneumonia. I think I would say, let me have a look at the sputum for myself, to find the "rusty" type, and let me see dyspnœa out of proportion to the physical signs, before making a diagnosis of an acute pneumococcal infection, for which chemotherapy is indicated.

Those of us who thought we knew how to guide a patient through lobar pneumonia have to gain fresh knowledge, with which to reconstruct our wisdom. If we knew disease plus patient; it is now plus drug. In some febrile illnesses it is plus daily Press as well. The lady in *Punch*, who asked if she was suffering from "the very latest form of influenza" is being replaced by the patient with a rise of temperature, who is asking for the very latest drug. I have seen more than one patient in the pre-icteric febrile stage of infective hepatitis, who has been given one of the sulphonamides. It is nearly three hundred years since Sydenham wrote: "It often happens that the character of the complaint varies with the nature of the remedies, and that symptoms may be referred less to the disease than to the doctor." This warning was not needed in my house-physician days, some forty years ago, when medical treatment was at its lowest ebb; but it is worth reviving with our new successful drugs.

Now one of the most interesting problems in the medical wards in the last twenty years or so has been the great increase in the number of serious cases of anæmia. My own immediate colleagues and many other physicians have done much to elucidate the problem. I have been in the wards long enough to say that I am quite sure that we did not have anything like so many cases in the first twenty years of the century. Those who have studied them closely have exercised the opportunity to gain clinical wisdom thence. I have learned to rely on my colleagues in the atypical forms. But where are they all coming from? Is bone-marrow not what it was? Or is it being poisoned? We must in times past have missed many cases of hypochromic anæmia in middle-aged women; and perhaps been severe with some foolish patient, who could not swallow a pill, when really she had the Plummer-Vinson syndrome. But these Addison's anæmias, achrestic anæmias and aplastic anæmias are undoubtedly more common; although formerly we might not have known one from another. I do not think we shall learn much more from looking down a microscope or from a sternal puncture. What was Kipling's question at the dinner of the Royal Society of Medicine? I think he advised the biochemist, when he made a discovery, to ask: "What was the state of the heavens when these phenomena occurred?" That might not help with the anæmias; but ought we to ask "what was the state of the atmosphere which these people breathed?"

I seem to have wandered from the theme as to whether it was more instructive to watch Dr. W. G. Grace bat or to be coached at the nets. Both are needed to perfect a batsman. It is a question of time and place. I remember as a registrar coaching an American medical man in medicine for the Conjoint. He fancied himself as a surgeon; had attended many confinements in fifteen years of practice; but was duly humble in our subject. He had been to a surgical demonstration where he saw a "wen on the head." He guessed he could have taken it out in his office in Chicago in less time than it took "your Mr. Rowlands to tell the boys what else it could be." I understood his trouble. I knew those journies round the surgical class. First came the ardent student with several coloured pencils, suggesting an osteo-chondro-sarcoma; then we left an opening for some nice fellow who had failed more than once to satisfy the examiners, and he would vote for a gumma; it was a pleasure to see his blush of pride as his bet was accepted; you could not put that horse out of the running with a Wassermann test before 1906. And so we went the round. I could understand that my American friend had found it tedious. But I stood up loyally for the surgical teachers; and I warned him not to put a knife into an aneurysm by way of diagnosis. We were firm friends. I was not surprised when he got through medicine, nor that he ploughed himself with both hands in surgery and midwifery. He had been warned.

I do think, however, that examination teaching should fit with time and place. What else it could be is, a fair question for a teacher to ask; but after a clear demonstration given with due sense of proportion of a typical clinical picture, I would have no such question from an earnest student. Some other time, in due season, he may get a demonstration of differential diagnosis; for example, of a case of spastic

paraplegia. One wonders if books ought to be written on diagnosis. They are really rather useful, but in a way they ought not to be. It is rather like the child's general knowledge paper. At first it gets set to test observation, with such questions as to how a horse gets up and how a cow. Then someone begins teaching the subject, so that a child can answer without having seen either quadruped. I once heard an examination teacher say that for a condition such as purpura, he would like all the causes to go up in the student's mind, just like one of those notices in a railway terminus of all the stations at which a train would call. Of course that brings full marks in an examination; but it is a long journey from simple purpura to hæmorrhagic small-pox, and one does not reach the diagnosis along the same line.

Perhaps the first step towards clinical wisdom is to learn the truth; that one goes into the wards to study medicine; but examination passing is partly a necessary evil and partly rather good fun. The undergraduate medical student must have his solid basis of facts. Who is he to exercise his fancy? It is only later in life as a teacher—either of himself or other people—that it is reasonable to suggest that so-called facts tend to have their day, but the right spirit lives.

I have rather a high opinion of a modern philosopher named J. Pope Clugston, whose essays are published in *Punch*. In a recent article he writes: "I very seldom learn anything new if I can help it, being troubled with too much salvage in the way of old facts as it is." There are doctors like that; often enough safe men, but they tend to lose interest in their profession. In Conan Doyle's volume, *Round the Red Lamp*, there is a tale called "Behind the Times," in which we read: "He is so very much behind the day that occasionally, as things move round in their usual circle, he finds himself, to his own bewilderment, in front of the fashion."

No doubt this refers to fashions in treatment. No one must be behind the times in the all-important problem of diagnosis. A wise summary of the whole case, however, is based on something less tangible but more important than facts.

Forty years ago, as a registrar, I recommended *Tales of Mystery and Imagination*, by Edgar Allen Poe, by way of lessons in observation. In more recent years for resident medical officers I have advised Chesterton's *Father Brown*. He could convict one murderer because a piece of paper was "the wrong shape" and acquit someone else suspected because, although anyone might commit a murder, that particular man could not commit that type of murder. Father Brown knew that a stick made the very best pointer, but had one serious drawback—the other end pointed in the opposite direction. The *Wisdom of Father Brown* is closely allied to clinical wisdom.

Tuberculosis of the Urinary Tract

By W. D. DOHERTY, M.A., M.Ch., F.R.C.S.

INFECTION of the urinary tract may occur as part of a generalised miliary tuberculosis or it may occur as a subacute or chronic localised disease. It is this latter condition with which this lecture is concerned.

How does the tubercle bacillus reach the urinary tract? (*a*) In the great majority of cases by the blood-stream. The organism can enter the blood-stream from some active or latent focus elsewhere in the body, chest, abdomen, bones, joints, etc. The disease in the urinary tract is always, therefore, a secondary manifestation, and this fact has an important bearing on the question of treatment (*b*) In some cases the infection may reach the urinary tract from a focus in the genital tract; for instance, a blood-borne infection of the prostate may infect the bladder, and later, by lymphatic or blood spread, the kidney.

What is the common site of infection? In blood-borne infections of the urinary tract the kidney is always the site of infection. The infection starts in one or more of the pyramids and is unilateral in most cases in the early stages. Later, the other kidney frequently becomes involved, probably by a further blood-borne infection. What is the course of the disease? It is most common in early adult life between the ages of twenty to forty years and both sexes are liable. Once the pyramidal region has been involved the typical tuberculous abscess is formed, and sooner or later this will burst into a calyx setting up the chain of pyelitis, ureteritis and cystitis. Actual tuberculous infection of these regions is preceded by a submucous small round-celled infiltration, so that the pelvis, ureter and bladder become grossly thickened. The

thickened ureter especially being one of the most characteristic naked eye appearances of a tuberculous renal infection. The changes in the bladder, which can be studied by cystoscopic examination are, first, hyperæmia around the ureteric orifice on the affected side followed by a generalised hyperæmia. Later, submucous tubercles may be seen which break down with the formation of shallow ulcers. The ureteric orifice undergoes some characteristic changes. Owing to the round-celled infiltration there is early rigidity of the orifice ; the peristaltic movements are no longer visible. Later, the shortening of the ureter from fibrosis pulls on the orifice and it appears large, round and rigid—the so-called " golf-hole " ureteric orifice.

In pelvis, ureter and bladder the submucous round-celled infiltration is replaced by submucous fibrosis with its inevitable contraction. One of the most distressing features of the disease is the small contracted bladder, which often remains even when the infection has been eliminated.

What are the end results of the untreated disease ? Tuberculous pyonephrosis is the usual sequel. But if there is a low-grade type of infection or the patient's resistance is high, then Nature may attempt to cure the disease by destroying the organisms and depositing calcium salts in regions where they have flourished. In this way a localised patch of calcification may occur or the whole kidney may become completely calcified with eradication of the disease. This is, unfortunately, a rare occurrence, and blood-borne infection of the other kidney with bilateral pyonephrosis and resultant uræmia a more likely sequel.

A tuberculous pyonephrosis may lead to a perinephric abscess and this, in turn, to a spontaneous urinary fistula in the loin.

Now a word about the *symptoms*. The most constant early symptom is frequency of micturition, and I would like to specially stress this point. Hæmaturia may occur, but there is seldom any renal pain or discomfort sufficient to localise the disease to one or other kidney. There is often a history of malaise and loss of weight if careful enquiry is made, but, again, this may be completely absent. It will be seen, therefore, that a case of persistent frequency of micturition in a young adult should call for careful *investigation*.

How should this be carried out and on what evidence is the *diagnosis made* ?

1. Urine examination.—The presence of a large number of pus cells in an acid urine and the failure to grow any organisms on ordinary culture media should always make one suspicious. The next step is careful staining of the centrifuged deposit and examination of many fields microscopically for the bacillus.

Negative findings in a single specimen should not be accepted ; further specimens taken over a twenty-four hour period should be carefully examined. In a large number of cases the bacillus will be found and the diagnosis confirmed, but failure to find the organism in the presence of an acid pyuria does not rule out the infection.

The final test should always be the injection of a guinea-pig with the centrifuged deposit. If the animal is killed six weeks after the injection active tuberculosis will be found, if it was present in the urine.

2. Whilst the urine is being tested, *intravenous* pyelography should be carried out; valuable information will be obtained from this examination. (*a*) There may be a difference in concentration of the dye in the two kidneys. This will, of course, be more obvious the greater the extent of the disease until, in an advanced case, the affected kidney will fail to concentrate the dye at all.

(*b*) There may be some irregularity in the filling of affected calyces.

(*c*) There may be some dilatation of the ureter on the affected side and, owing to the rigidity, it may have lost its tortuous appearance.

(*d*) The appearance of the bladder in the cystogram is generally small and contracted; evidence of spasm and fibrosis.

The urine examination and the intravenous pyelogram will probably have established the diagnosis and the latter may give a clue as to which kidney is involved. Before treatment is undertaken exact localisation of the disease must be made. This is done by *cystoscopy* and ureteric catheterisation. The cystoscopic appearances of the bladder are as described earlier. The small inflamed, possibly ulcerated, bladder confirms the diagnosis, but again the appearance of the ureteric orifices may give a further clue to the side involved. A specimen of the bladder urine is obtained and then ureteric catheters are gently passed and specimens obtained from either kidney. Naked eye there is generally a pale turbid urine from the affected kidney. All three

specimens are sent to the bacteriologist with a request that if tubercle bacilli are not found, guinea-pigs should be injected from each specimen separately. By these means it should be possible to say whether one or both kidneys are involved and which kidney is at fault. But the evidence must be beyond all shadow of doubt and, if there is any the ureteric catheterisation should be repeated, if necessary more than once, until the localisation is definite.

Treatment. If the disease is localised to one kidney, in the absence of any other contraindication, that kidney should be removed. The reason for advising this drastic step is fear of the sequelæ mentioned previously and especially the infection of the other kidney. But removal of the kidney is only a step in the treatment of the disease. This cannot be too strongly stressed. We have seen that kidney infection is always secondary to disease elsewhere in the body and, whether this has been localised or not, it has got to be treated on medical lines and an attempt made by raising the resistance of the patient to prevent its further spread. So, following the nephrectomy for unilateral renal infection, the patient should be sent to a sanatorium, where he should remain for three to six months, and then be kept under observation for a further two years.

The *results* of treatment are disappointing unless the disease is diagnosed in its early stages. The chief disability in advanced cases is due to the small contracted bladder, which in time leads to hydronephrosis of the sound kidney with eventual atrophy. Early diagnosis will only be made if all cases of frequency of micturition in young adults, which persist in spite of treatment, are fully investigated.

"Distinguished Gathering"

TONY BREWIN, in his production at Guy's on February 1st, 2nd and 3rd, 1945, of "Distinguished Gathering" by James Parish, managed to secure a quite extraordinary number of good actresses. Rarely are the female parts filled so well. Gillian Debenham as Judith Montague gave a most convincing performance, in spite of the fact that she did not look strong enough to bury a foot-long dagger up to its hilt in the spinal column of the wretched Mr. Vines. Equally good was Beryl Moore as "Lesley Gest" and Jean Thomas and Gertrude Schwer made the best of two dull ladies called Caroline Beckwith and Lady Thalia Wilmer. Indeed most of the characters, libelled so expertly by Mr. Vines, seemed terribly dull with the possible exception of little Mrs. Caswell, played by Doreen Northam. Miss Northam gave us plenty of laughs but did not, in fact, look old enough to be the sophisticated woman she was meant to be.

Mr. Brewin himself shouldered the part of Felix Montague, a boring gentleman, whose only purpose seems to be to allow the play to revolve round him, and as usual, Mr. Brewin's acting was excellent; but he deserves a better part than this. He is, however, to be congratulated, since he undertook the leading part at very short notice. Peter Barrett as the loathsome Mr. Vines was a delightful surprise. He oozed beastliness most effectively and Mr. Barrett is obviously an experienced actor. One hopes to see him again in future productions. The rest of the caste consisted of Ted McGuire as C. D. Williams, James Breese as "Runty," Raymond Luffingham as Sir Brian Howett, Alan McLauchlin as Blair, and Gordon Nicholson, Colin Watson and Roger Glenn as the three policemen. Probably the best feature of the play was the well-drilled acting by the whole team, and the play showed signs of thorough rehearsal and careful production. Lighting was poor and D. S. Noble was working with quite inadequate material. The stage was managed by E. Killey, and J. L. Warren looked after make-up.

On Saturday night, during his "thanks-for-coming" talk to the audience, Mr. Brewin expressed the wish that it might in future be possible to form a permanent dramatic society which would be recognised by the Clubs' Union and that, when the rebuilding of Guy's was begun, room should be found for a permanent stage with proper equipment. On reflection one is amazed that such matters have not been dealt with long ago. There has never been a lack of dramatic enthusiasm at Guy's and, with the increasing number of good actors among present-day students, these measures seem most desirable, if not essential, as far as the formation of a proper club is concerned. A permanent stage would be an enormous advantage, because without it no long-term policy with regard to scenery and other material can possibly succeed.

One hopes that Mr. Brewin's remarks will not pass unheard. C. T.

Play at Farnborough

ON Friday and Saturday, January 26th and 27th, 1945, "I Killed the Count," by Alec Coppel, was presented by the Farnborough Hospital Dramatic Society. This fearsome title concealed many members of the able team who acted "Ten-Minute Alibi" so well at Tunbridge Wells in 1943.

Dennis Forsdick, the producer, has once again provided an excellent entertainment. Michael Coplans as Samuel Diamond, the opulent business man, complete with emerald signet ring and cigar, was a grand study and the part came to life in the most remarkable way. Mr. Coplans is an eminently satisfactory and competent actor, and one hopes to have an opportunity of seeing him act at Guy's. All this must be said, too, of Rodney Long as Viscount Sorrington. Mr. Long's tall figure, immaculately dressed, combined with his fine speaking voice, portrayed his lordship beautifully. John Hayward, as Detective-Inspector Davidson, coped well with a part which is of prodigious length. Scarcely off the stage for more than a few minutes in two and three-quarter hours, he gave us some very good acting. Several newcomers appeared in the caste; John Crossley as Martin and Irvan Yentis as Mullet deserve special mention. Both parts were excellently played and Mr. Crossley is obviously a very talented actor. Of the ladies, Polly the housemaid, was played by Irene Rudd, whose sound acting made a good deal of a small part. Brenda Johnson played the gorgeous "La Lune", and Rachael Bell, Louise Rogers, Mr. Long's swooning daughter, whom it appears really committed the murder.

Other parts were taken by Ernst Leiser, Peter Read, Robert Barnard, David Strange and Peter Carton-Kelly, and the stage was operated by J. G. Stebbing and D. S. Hurwood, both of whom are to be congratulated on the excellence of the set, a matter of considerable difficulty in war-time. Make-up was undertaken by B. C. Morgan, and Mr. Stebbing's assistants (including the one discovered on the opening of the double doors) were J. D. Oriel, David Rahilly and others.

Mr. Forsdick and his team are much to be congratulated and one looks forward to their appearance in a production at Guy's. C. T.

Correspondence

STUDENTS IN TEACHING HOSPITALS.

To the Editor of the GAZETTE.

SIR,—The most charitable view one can take of the "Passim" of February 3rd, 1945, is that it was deliberately written to provoke discussion on the subject of teaching hospitals; whether other readers of the *Gazette* will take this view remains to be seen.

This Hospital is extremely proud, and rightly so, of the relationship that has always been maintained between the students of the Hospital and the Borough. In the wards this relationship is strengthened, and the student is a vital link between the anxious patient and the harassed and overworked house-surgeon.

His case-histories are of genuine value at the time, and are often of supreme value, especially if the patient ever has occasion to revisit the Hospital. The patients seldom, if ever, resent the student taking a case-history, and to assume that it consists of a series of questions asked by a tactless and incompetent student is an unwarrantable assumption.

A student's examination of a patient, while naturally not as polished as that of the fully qualified, is most certainly not "an unnecessary repetition of painful and even dangerous manipulations." To describe it as such is an insult to the intelligence and ability of the students of this Hospital.

To conclude that any student in the Hospital has callously thought of a patient as "a diseased organism" is a conclusion drawn solely by the writer of "Passim," and, unless he can substantiate such statements, he should refrain from making them public.

Yours, etc.,

Guy's Medical School, S.E.1. R. A. KEABLE-ELLIOTT.

FAIR TREATMENT FOR PERIODICALS.

To the Editor of the GAZETTE.

SIR,—The Library Committee are anxious that periodicals should be available as freely as possible for all using the Library. At their last meeting, when passing periodicals for binding, they were distressed to find that in a number of cases articles had been torn or cut out. The selfish action of a small number thus prevents their fellow-students having the advantage of these articles, and the loss may be felt for a considerable time, as it is not always possible to replace the numbers that have been damaged, and the volumes may have to be bound without them.

The Library Committee hope there will be no repetition of this, as they do not wish to reduce the facilities now available.

Yours, etc.,
MAURICE CAMPBELL,
Hon. Wills Librarian.

MEDICAL STUDENTS AND INTERNATIONAL RELATIONSHIPS.

To the Editor of the GAZETTE.

SIR,—I was most interested to read in a recent edition of your *Gazette* a letter from Mr. Doherty, in which he makes a plea for closer co-operation between medical students of different countries and an exchange of visits between those students and ours after the War.

The subject of international relations has been the concern of the British Medical Students' Association for some little while, and we believe that we have definitely made advances in this field. We started by appointing an international secretary, whose function it was to contact the main medical student bodies in all the Allied and "friendly" neutral countries. (Many difficulties arose in trying to decide which were friendly and which were hostile.)

We have made considerable progress in the past few months and we have laid the foundations towards the understanding of their ways of life, their methods of study, and the problems of their country. "How does the other man live, what is he thinking about and, if he is troubled, how best we can help him?" We set ourselves the task of discovering the answers to these questions and, having discovered them, of applying our full energies towards the fulfilment of a better understanding between one section at least of a strange land and our own.

Yours, etc.,
GERALD W. KORN,
Public Relations Officer to the B.M.S.A.

B.M.A. House,
Tavistock Square, W.C.1.

Guy's Hospital Squash Rackets Club

THE squash club is as active a member of the Clubs' Union as ever, and there are many keen players to be found in the Hospital; we are running a tournament, too, by which still more hidden talent may be discovered.

Although the standard of squash-playing has been lower this year than formerly, enthusiasm being but a partial recompense for skill, the team itself has had fair success up to the present. We have won four matches—St. Mary's being one of our victims—and have lost an equal number.

Your correspondent, "a lamb before the shearers," plays No. 1. At Nos. 2 and 3 are R. Freeman and J. D. L. Reinhold; their knowledge of tennis and jiu-jitsu respectively, rendering them formidable opponents and effective at winning matches. No. 4, D. R. S. Saunders, cannot quite forget the cricket-field; his "wrong 'un" puzzles many a skilful player—and he's an invariable winner. J. E. Attale—No. 5, and a social asset to any side, usually finds his form and the ball simultaneously at the beginning of the third game. We are lucky to be able to call upon A. B. Shein, for home matches as he strengthens a weak side.

L. D. Carton-Kelly and R. G. Brittain have helped to make up the team from time to time.

Finally, I would urge all those of you who are aspiring squash players, to start at the bottom of the squash ladder and try to work your way up. P. S. C.-K.

Sport

Rugby

GUY'S *v.* MIDDLESEX HOSPITAL.

(*Played at Chislehurst on January 6th*, 1945.)

Middlesex Hospital won this game by 2 goals and 2 tries (16 points) to nil.

The game was played under difficult circumstances; rain having softened the surface of a frozen ground and making handling difficult. Despite this the Middlesex backs were able to carry out some fine movements.

The scoring started early when Dryden, the Middlesex stand-off half, cut through and scored near the posts, but the kick at goal went wide. This was followed by a period of pressure by our forwards causing the Middlesex defence some anxious moments. Finally, Middlesex broke away and, shortly before half-time, Colson, in the centre, rounded off a fine passing movement by going over near the corner. Arthur converted.

After ten minutes of the second half MacIver scored following a grand run by Colson. The kick at goal failed, the ball bouncing along the cross-bar and dropping back. Shortly before time Seidelin (Middlesex scrum-half) forced his way over following a scrum near our line. Arthur converted.

As usual the forwards played a good game and held their own. They should, however, learn to co-ordinate their efforts in the loose. The heeling was ragged so that Willcock, the scrum-half, was frequently caught in possession of the ball. From the kick-off the backs were outclassed, but Macrae-Gibson, playing a fine defensive game at stand-off half, provided some satisfaction for the Guy's supporters. In attack, movements lost their punch through bad passing and bad backing up. Gray, at full back, was very cool with a safe pair of hands and made many good kicks to touch. The wings did not have their fair share of the game.

GUY'S *v.* ALDERSHOT SERVICES.

(*Played away on February 10th*, 1945.)

If ever a team deserved to win a match Guy's did this one, and were most ill-fated to lose by 2 goals to 2 tries and a penalty goal.

The Services, playing down wind, scored a try after twelve minutes, which was converted. Shortly after this Le Clus kicked a fine penalty goal into the wind, but the Services immediately increased their lead, when an unmarked forward broke through from a line out on the Guy's line and scored. The kick was again successful.

After half-time both fate and the weather were against Guy's. Guy's were soon on the attack and Macrae-Gibson crossed for a try after a good run. The kick failed. Billingham went close with a long drop at goal shortly afterwards. Guy's were now definitely on top and ten minutes from the end Macrae-Gibson scored between the posts after he gathered the ball, following a long run by Davis, who was tackled on the line. Unfortunately the kick was missed owing to a misinterpretation of the rules. In the closing minutes, following a good cross kick by Macrae-Gibson, Selley apparently scored, but the try was disallowed.

Hilliam, leading the pack, played his usual fine game and was well supported by McCallum and a newcomer, Walker; but the back row was lamentably slow. When the forwards did get the ball back Billingham, at stand-off half, showed great promise. In fact, the whole back division was in fine form and it was a great pity that they were not given more chances.

Association

Although the soccer side have not had a very successful season so far, Guy's standing very near the bottom of the League table at the present, the Cambridge match has shown that when we are able to turn out a full side we have an eleven that is comparable with last season's side.

Newcomers to the side have improved greatly since the beginning of the season. I. L. Busbridge in goal, out of action last season because of an injury; and H. R. Riches at centre-half, both of whom used to play in the eleven of the Tunbridge Wells days, have shaped well. R. A. C. Dove has also returned to soccer and has played very well as left back; while, in W. E. Evans, we have a promising inside forward who should be with us for several years yet.

One reason for lack of success has been the fairly regular selection of at least one Guy's player into the London University and United Hospital sides. Members of the club who have played for one of the clubs or both are E. G. Murphy (captain of the United Hospitals A.F.C.), M. J. L. Sykes, I. A. H. Munro, R. Owen and I. L. Busbridge.

M. J. L. SYKES
(Hon. Sec.).

GUY'S *v.* BOROUGH ROAD COLLEGE.

(*Played at H.O.P. on February 3rd*, 1945.)

Result: Won 4–2.

Guy's did well to beat the Borough Road side, who were at the top of the League at the beginning of the season.

The game was fast throughout the first half though, towards the end of the match, the pace began to tell on both sides due to lack of recent play.

Guy's opened the scoring after about ten minutes of play, R. Owen scoring after a tussle in front of goal. Five minutes later Borough Road equalised from an attack down their left wing.

A. E. Trist scored next for Guy's after a break-through down the centre, hooking a hard shot into the net. Just before half-time R. Owen again scored, giving the Hospital a 3–1 lead.

Early in the second half Borough Road forced a corner from which they scored.

Fifteen minutes later I. A. H. Munro headed a goal from a centre from the left wing. Shortly before time Borough Road nearly scored a third goal, but the ball was cleared on the goal-line by H. R. Riches.

Team.—I. L. Busbridge, C. S. Matthews, R. A. C. Dove, E. M. Newton, H. R. Riches, R. S. M. Young (captain), I. A. H. Munro, M. J. L. Sykes, A. E. Trist, W. E. Evans, R. Owen.

GUY'S *v.* CAMBRIDGE UNIVERSITY.

(*Played at Cambridge on February 8th*, 1945.)

Result: Lost 2–3.

Guy's travelled to Cambridge with the task of avenging recent Hospital defeats there and were far nearer to bringing it off than the score would suggest.

With the exception of C. S. Matthews, who stood down because of examinations, Guy's were able to turn out a full side for this mid-week game against a full University side.

The Grange Road ground was in almost perfect condition and from the start it was obvious that it was to be a close game. Guy's soon settled down to playing accurate constructive football and held the well-trained Cambridge side for the first quarter of an hour.

The sound strong-kicking and close-passing, always a feature of Cambridge football, was well matched by Guy's, who developed a fighting spirit recalling last season's successes.

Although Cambridge scored three goals in the first half their forwards were for the majority of the time well marked and allowed little latitude, but they made use of the few chances they did get. After the first Cambridge goal Guy's had a chance to draw level when they were awarded a penalty, but the opportunity was missed. After this period lasting a quarter of an hour, in which Cambridge scored their three goals, Guys recovered and there was no further score up to half-time.

In the second half Guy's completely dominated the play, the ball being in the Cambridge half most of the time, most of the play falling on the wing halves and inside forwards, who worked well together and made plenty of use of R. Owen playing well on the left wing.

After a short while Guy's scored their first goal, a shot from M. J. L. Sykes being deflected by a Cambridge back into the net.

Guy's second goal came from a free-kick just outside the penalty area, which R. K. Foster scored, driving a very hard accurate shot into the side of the net. A good shot from W. E. Evans might have brought Guy's their second goal a little earlier, but the Cambridge goalkeeper, Davies, made a very fine save.

Guy's struggled hard for their third goal, but in spite of a last minute change, E. G. Murphy moving into the forward line, it was not forthcoming.

Throughout the second half particularly the defence was sound, R. A. C. Dove playing a brilliant game.

Team.—I. L. Busbridge, E. G. Murphy, R. A. C. Dove, R. S. M. Young (captain), H. R. Riches, G. Roberts, I. A. H. Munro, M. J. L. Sykes, R. K. Foster, W. E. Evans, R. Owen.

Hospital Information, etc.

Notices

GUY'S HOSPITAL STUDENTS' UNION.

Sir Harold D. Gillies, C.B.E., F.R.C.S., will give an address on "The Primary Treatment of Facial Injuries and other aspects of Plastic Surgery" (illustrated by a short film), at 5.15 p.m., in the Anatomical Theatre, on Tuesday, February 27th, 1945.

Pass List

ROYAL COLLEGE OF PHYSICIANS OF LONDON.
January, 1945.
M.R.C.P.

C. F. Hawkins, M.B. (Lond.).
Captain J. C. Houston, M.B. (Lond.).

UNIVERSITY OF LONDON.
FIRST EXAMINATION FOR MEDICAL DEGREES.
(*For Internal Students.*)
December, 1944.

T. B. Brewin	J. A. Loeb
J. C. B. E. Carreras	M. Mason
K. R. Heber	E. W. Melia
E. M. Hume	J. B. Parsons
G. A. Lawrence	G. R. Williams

(*For External Students.*)
S. R. W. Powell

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
January, 1945.

Surgery.—*K. Lewis, J. Wotton.
Medicine.—*A. St. J. Dixon.
Midwifery.—N. C. T. Watford.
* Have completed the examination.

Papers by Guy's Men

Braithwaite, J. Vernon. Disorders of Childhood. *Post-Grad. Med. J.*, 1944, **20**, 350.

Reeve, E. B., and Neville, N. A. A simple standard procedure for obtaining blood having a hæmoglobin content identical with arterial blood. *Clin. Sc.*, 1944, **5**, 1.

Clarkson, Patrick, and Another. Early fitting of Temporary Facial Prosthesis. *Brit. Dent. J.*, 1944, **77**, 356.

Rewell, R. E. Internal Hydrocephalus complicating Pneumococcal Meningitis treated with Penicillin after Sulphonamides. *Brit. Med. J.*, 1945, i, 119.

Change of Address

Miss B. A. Blewitt, P/333307, Q.A.I.M.N.S/(R)—R.F.R.K.V., A.P.O., India Command.

P. Fourman, Lieut., R.A.M.C., 317822, Imperial Bank of India, Bombay.

G. O'Gorman, Captain, R.A.M.C., 6 Base Psychiatric Centre, C.M.F.

S. McK. Saunders, Colonel, R.A.M.C., O/C 16th British General Hospital, M.E.F.

Graham V. Steward, B.Ch., Hazeldene, Chipstead, Coulsdon, Surrey.

L. P. J. Wright, Captain, R.A.M.C., 6 Base Psychiatric Centre, C.M.F.

Awards

M.B.E. (*Civil Division*).

Dr. H. F. Sparling, Medical Officer, Shelter Medical Aid Post, Civil Defence Casualty Service, East Croydon, in recognition of services rendered to victims of flying bombs

Births

MIDDLETON.—On January 20th, 1945, at Guy's, to Diana (née Dartnall), wife of Major Robert Middleton, A.D. Corps (Overseas)—a son (David).

Deaths

FORD.—On February 2nd, 1945, as the result of an accident, Surg.-Cmdr. (D) William Charles George Ford.

JOHNSON.—On February 3rd, 1945, at his home in Shefford, Bedfordshire, William John Johnson, M.D. (Lond.), aged eighty-one years.

PETERS.—On January 29th, 1945, after a short illness, Edwin Arthur Peters, M.D., F.R.C.S., late of 41, Wimpole Street, W.1.

WALLIS.—On February 6th, 1945, at Worthing, Charles William George Robinson Wallis, B.A. (Oxon), M.R.C.S., L.R.C.P., aged eighty-six years.

WALMSLEY.—During August, 1944, in action near Paris, Eric Stanley Walmsley, L.D.S., R.C.S., Walcots, Wallingford, Berks.

WINSTON.—Killed in action on January 28th, 1945, in North-West Europe, Lieut. Peter Stanley Winston, Royal Marine Commandos, dearly loved younger son of Mr. and Mrs. J. H. E. Winston, 213, Upper Selsdon Road, Sanderstead, Surrey.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1477 *3rd March, 1945* *Ninepence*

PASSIM

OLD Guy's men may be interested to hear about an alteration in the former age-hallowed Front Surgery system. The first indication that something new was afoot was in the middle of January, when there appeared simultaneously in Front Surgery a new set of dressers and some large out-patient cards, decorated in tasteful hues of blue and red and black, and divided into portions by perforated lines. Next, and to the accompaniment of carpenters and an infernal noise, there grew up in Out-patients' Hall a new enquiry bureau, in proportions, splendid and in colour, pink; it was made of wood—pink wood. Long we pondered; then in a flash we saw it all, and how exciting it seemed. There was the lovely new, pink bureau; in it would sit a young lady dressed in green, and she would dispense blue and black and red perforated cards all day long to queues and queues of patients, and now they wouldn't mind waiting a bit. Oh better, brighter medicine—and what will they think of next!

But as the painters and varnishers set to work on the new, pink bureau, turning it into a dull shade of mock oak, so were those rosy dreams tarnished also; for the truth of the matter is, the inspiration of these bright new schemes is our old grim friend, Financial Want. The system has been devised to assist the almoners' department in their new task of collecting a shilling a visit from every out-patient who does not belong to the H.S.A. It is hoped that this will encourage patients to join the H.S.A., the insurance scheme, the premium of which is threepence a week. That hope appears to be partially justified already. Needless to say, anyone who cannot or will not pay his shilling gets his treatment just the same.

The plan, which includes raising the weekly charge for medicine from one shilling to half-a-crown, is yet in its infancy and there are still teething troubles; but it will be interesting to watch its development.

WE publish in this issue of the *Gazette* the first part of an article on the clinical aspects of criminology by Dr. Norwood East. It is opportune that our attention should be thus directed. Dr. East concludes that a large though uncertain proportion of peace-time criminals would benefit from psychotherapy; and there is no reason to expect that the proportion of war-time offenders who would gain from such treatment is smaller, especially as an unfavourable upbringing and environment may be imputed more often in war-time than in peace. As the end of Europe's war approaches, so we look to our plans for the straightening of the twisted minds of the youth of Germany. We may read about these schemes and counter-schemes in articles in the daily Press; but at the same time, scrutiny of the news columns of those very journals prompts us to hope that we will plan the management of Britain's own difficulties, less grievous though they be, in a similarly grand manner.

IN the last "Passim" we asked a question, "What has become of Guy's rugger?" This time we ask, "Have you seen what's happened to Guy's boxing?" For while self-reproach concerning the former was in season, it is now not untimely to express gratification at the prosperous rebirth of the latter. The boxing club appears to be established now on a basis firm in both the quantity and quality of its members. Incidentally, it was the old Guy's we saw at H.O.P. on February 17th playing with some of its old skill and spirit against the R.N.Z.A.F.

READING through our Bart.'s contemporary we chanced upon a proposal for an original way in which to celebrate victory. It was suggested that a football match should be played between Bart.'s and Guy's; that the goals should be the fountains (?) in the respective hospitals' courtyards; and that the only rule would be one forbidding the hurling of opponents into the Thames from off London Bridge—this rule to be waived under special circumstances. May the fixture be for this year then!

Clinical Aspects of Crime

By W. NORWOOD EAST, M.D., F.R.C.P.,

Special Consultant to the Royal Navy; formerly H.M. Commissioner of Prisons, England and Wales, etc.

An Address delivered on May 23rd, 1944, before The Oxford University Medical Society.

CLINICAL ASPECTS OF THE PAST.

GENTLEMEN,—Since the time when Abel was murdered by his brother and blind Isaac was defrauded by his wife and son, the history of crime is largely the history of the men and women of the times. An act may be a crime at one period and not at another, and although the law punishes less severely than formerly it frequently prohibits behaviour which was not previously regarded as criminal, and imposes penalties upon those who break the prohibitions—for example, upon those who hoard food during war-time, or exhibit a light from a building during black-out hours.

The modern scientific approach to crime is modifying many of the views regarding the causation of crime and the treatment of criminals which were accepted by the different schools of penology in the past. The so-called classical school is associated with the name of the eighteenth century Italian publicist Cesare Beccaria, who influenced many of his contemporaries by his humane ideas. Samuel Romilly, the legal reformer, and Jeremy Bentham, the philosopher-jurist in the early years of the nineteenth century, supported in this country Beccaria's views. The prevention of crime rather than punishment, and the prompt application of punishment when it was inevitable were recommended, and confiscation, torture and capital punishment were condemned. This school considered that criminal conduct was deliberately selected after a careful examination of its advantages and disadvantages, and it believed that no more punishment was required to prevent crime than to render the advantages unattractive.

The neo-classical school which followed recommended that different degrees of moral and legal responsibility should be considered as well as the circumstances of the crime. The necessity to treat the offender rather than his offence is a development of the fundamental principle of this school.

The later positive school held that the criminal was predestined to a criminal career on account of his inherited traits and that he was therefore wholly irresponsible. The positivists considered that it was wrong and foolish to punish the criminal as if he were a free agent and able to select his course of social conduct. It aimed at the scientific approach to crime, and although many of the assumptions upon which it was based are no longer accepted by the modern school a brief reference is due to the work of some of its protagonists.

The discoveries of Francis Joseph Gall in the anatomy of the brain and nervous system during the early years of the nineteenth century will always remain outstanding. His idea that the underlying structure of the brain affected the formation of the skull, and that, in consequence, character could be foretold by the external examination of the head, although erroneous, was accepted by other earnest observers and influenced the thought of the period. Gall's observations and phrenological diagnoses of character caused Carus, Lauvergne and others to study the criminal from the anthropological point of view. In the latter half of the nineteenth century Lombroso's anatomical and physiognomical studies led him to consider that he was able to distinguish the criminal he believed to be born as such from the criminal of habit, passion or occasion, whom he believed was born with very few or no normal characteristics. Galton, in 1883, referred to the "degradation of expression" in English convicts when sorting their photographs in his experiments with composites, and as late as 1914, Havelock Ellis agreed with the statement made by Hepworth Dixon in 1850, that the criminal countenance was at once repulsive and interesting.

Earlier observers investigated the physical sensibility of criminals with enthusiasm. Lombroso found the general sensibility was diminished in more than half his cases. Marro found insensibility, measured by the esthesiometer, most obtuse in murderers and incendiaries. Ramlot found tactile sensibility was more obtuse among criminals than in normal persons. Bono and Ottolenghi found the eyesight of criminals superior

to the normal, but previous observers took an opposite view. Gradenigo found defective hearing present in the majority of criminals. Ottolenghi found olfactory and gustatory acuteness were below the average of non-criminals.

In 1901 I examined one hundred convicts and found that sensation was impaired in the five special senses when assessed by the acuity of ten medical friends at Guy's Hospital. The observation would have been more significant if the controls had been drawn from the same social class as that from which most of the criminals came.

At one time the frequency of tattooing among criminals was alleged to be an indication of their insensibility to physical pain. But of five hundred convicts I examined only 43 per cent. were tattooed, and this seemed to be no more than was usual among the men of the fighting services of those days. Looking back forty years it seems that the scientific value of these various observations is insignificant, since the number of cases examined was usually few and statistical methods of investigation were undeveloped according to modern standards. Nevertheless, they do mark the birth of the attempt to understand criminals on a scientific basis.

CLINICAL ASPECTS OF THE PRESENT.

As already stated, the positive school of penology held that the criminal was predestined to a criminal career on account of his inherited traits, and it is an interesting matter for speculation whether this view was in any way encouraged by the ideas which the cultured classes of the time seem to have held regarding those who were looked upon as social inferiors. It is also not without significance that the word "penology," meaning the study of punishment, has been largely replaced in modern times by the word "criminology," the science of crimes. If we accept the view that human behaviour is based upon the innate tendencies which cause us to act in a certain way in a particular situation, and are essentially similar to the instinctive tendencies of animals, it would appear that we are all born with criminal tendencies whatever our social position, because each one of us is endowed with acquisitive, sexual, aggressive and other impulses as part of our biological constitution, and our resulting behaviour will not become socially acceptable of its own accord. Since cultured society is based upon the principle that the interests of the individual must be subordinated to the welfare of society, and that the instinctive tendency to take from others, to have sexual contact with, and act aggressively towards them can only be permitted within certain limits and in certain circumstances, it is necessary for training in the home, the school, and the outer world to direct behaviour into the accepted patterns by precept and example; and, if necessary, by the imposition of penalties and imprisonment.

The hereditary factors of criminality have been studied by many observers. In an investigation carried out under my direction at Wormwood Scrubs Boys Prison in the years 1930–1936 on 4,000 adolescent offenders from the London and surrounding areas it appeared probable that for some of the lads a criminal family history was a causative factor in the commission of further offences after the first conviction. The subject bristles with difficulties, but the researches of Lange, the Rosanoffs and Handy, Kranz, Stumpfl and others on similar and dissimilar twins lead to the conclusion that heredity alone is not a cause of criminality. As Lange points out, however, "the twin method can merely teach us that the tendencies which lead to anti-social behaviour develop in the domain of heredity."

It is a recognised fact that mental defectiveness and mental disease may be the result of inherited factors which may be associated with criminal behaviour. Further, personal characteristics in the parents may be socially useful in themselves, but may lead to crime when amalgamated in the children. But modern observers find no sufficient reason to consider that crime itself is inherited. On the other hand, the extremists who assert that crime is the product of environment alone are unsupported by scientific judgment.

Clinical observation suggests that heredity is a more important crimogenic factor in some cases and environment in others. But it is often difficult or impracticable to balance their relative significance. Many observers to-day accept the view that in determining the probability that a given individual will commit crime the hereditary factor is of primary importance, and the environmental influences determine the form the crime will take.

A learned judge (Cave, J., in *Chisholm* v. *Doulton*, 1889 22 Q.B.D. 736) declared that: "It is a general principle of our criminal law that there must be as one ingredient

in a criminal offence some blameworthy condition of mind. Sometimes it is negligence, sometimes malice, sometimes guilty knowledge, but, as a general rule, there must be something of that kind which is designated by the expression '*mens rea*.'" It is unnecessary to consider here the abstractions which have entered into the legal explanations of this term. But the doctrine that it refers to anything that is morally wrong was, according to Fitzjames Stephen, considered to be highly questionable by eminent judges in the past, and many acts which are immoral in the ordinary sense of the word are not criminal, and some which are not immoral are criminal.

In former times Ecclesiastical Criminal Law was a powerful institution in this country, and civil and ecclesiastical legislation went hand in hand. Stephen referred to the fact that nearly every set of secular laws enacted by any of the early English kings was coupled with an ecclesiastical code, or contained ecclesiastical provisions. The bishop and the earl sat side by side in every county court. Ecclesiastical offences could be divided into two main groups—namely, those which were not sexual in character, amongst which perjury, defamation, witchcraft, breach of faith and drunkenness were the most important; and those which were connected with the relations of the sexes and were not punishable as crimes by the common law of the time, such as incest, bigamy, acting as a procuress, producing abortion, overlaying children and attempts to ravish. The jurisdiction of the Ecclesiastical Courts upon matters of this kind was so extensive that they sometimes interfered in quarrels between married people. For several centuries, however, as Stephen pointed out, the history of the Ecclesiastical Law in this country has been a history of decay.

Environmental crimogenic factors have also received attention. As a result of his investigations into juvenile delinquency in the Liverpool area Bagot concluded that "there is no doubt that psychological conditions of great complexity and influence are present in many of the delinquents, and they should be taken into consideration when treatment is being administered; but such conditions, although found in children of all classes, do not, it has been shown, bring children from the better classes before the court. The present inquiry, therefore, leads to the conclusion that environment factors must be held to be the principal causes of such delinquencies as appear in court. The rareness of delinquents from even comfortable families emphasises the powerful influence of poverty." Bagot compares delinquency with tuberculosis: "Both flourish in poverty, overcrowding and squalor, ignorance and wrong upbringing are vital factors in both; and just as tuberculosis sometimes appears when conditions are good, so does delinquency." There is, however, no reason to consider that crime is a disease and the analogy may be harmful if it suggests that this is so.

The Feversham Committee considered lack of discipline and control in the home to be a major cause of juvenile delinquency: "Sometimes the discipline is over-harsh and sometimes over-lenient; or it may consist of erratic swings between severity and slackness. The "broken" type of home is also a subversive factor, but homes broken by natural causes, such as the death of a parent, are not so harmful as homes broken by desertion, persistent friction between the parents, alcoholic indulgence or betting. Under this heading we must consider an *omnibus* cause usually termed "bad influence." This may be taken to mean on the part of parents and companions an attitude of indifference to, or acquiescence in, low standards and anti-social behaviour; in certain cases there is also active encouragement of crime by gangs. The absence of active counter-balancing influences in the direction of socially acceptable behaviour has often much to do with delinquency."

The investigation at Wormwood Scrubs Boys Prison studied in considerable detail the environmental factors associated with the lads' homes, schools and occupations. It is not my purpose to enumerate them here, but it is important to note that the material aspects of the environment may be less important than the psychological influences. So it comes about that a poor but happy home may more favourably affect social conduct than a prosperous home in which there persists an atmosphere of selfishness, disloyalty, suspicion and hostility.

Parental control when properly exercised has the advantage of being immediate, but its effects are usually gradual, and each precept or admonition should serve as a basis for a better personal code of behaviour and a better idea of social duty.

There can be little doubt that religious training and discipline are less applied to the practical affairs of daily life than formerly. Material desires replace moral values, and the satisfaction of the moment supplants a long-term advantage. Many parents appear to have no sincere moral convictions, and the resulting spiritual impoverishment tends to express itself in anti-social behaviour which, like criminal behaviour, is essen-

Correspondence

THE COLLEGE CATERING COMPANY.

To the Editor of the GAZETTE.

SIR,—In view of the widespread criticism which has been directed against the College Catering Company, the view was expressed at the recent annual general meeting of the Students' Club that the following facts relating to the history and financial position of the Company should be publicised.

For many years prior to 1927 catering in the College was undertaken in turn by stewards or outside catering concerns, all of which proved either unsatisfactory or financial failures. Because of excessive prices charged for meals, lack of variety in menus and many other reasons a general meeting of staff and students was convened, at which it was agreed that a further attempt should be made to organise the catering within the Hospital itself. Early in 1927 it was decided to form a private company which would be able to trade in the open market and benefit by the wholesale prices it could obtain.

It was estimated that the initial capital required to start the concern would be about £1,000, so a private company, now known as the Guy's Hospital College Catering Company was floated, and members of the staff were invited to take up £1 shares in this concern. Eight hundred and twenty shares were taken up, but when it was ascertained that only half of the estimated outlay would be required it was decided to call up not more than three-fifths of the share capital—*i.e.*, £492. Since then a further ten shares have been allotted, so that the share capital up to date is £498, representing 830 shares, leaving a balance of £332 to be called up if necessary. The Board consists of ten directors—*i.e.*, six members of the staff, three student directors (two student representatives and the honorary secretary of the Students' Club), and the President of the Residents, so that staff, students and residents are all represented on the Board. The directors receive no remuneration for their services, but the shareholders receive a dividend of 6 per cent. on the paid-up share capital of the Company, which amounts to £30 per annum; but as the sum of £15 is deducted for income-tax the net cost to the Company is £15 per annum. Reference to the memorandum and articles of the Company makes it clear that the objects are to benefit the members of the Clubs' Union and the Students' Club in particular.

The first year was moderately successful, but during the first half of the next year the catering deteriorated, and the average loss was over £100 per quarter. A complete change in management was then effected and since that time highly satisfactory results have been achieved. Step by step prices were reduced, quality of meals improved, larger portions provided, and extra courses supplied without adding to the cost. Eventually, the Board was able to supply substantial meals of good quality and wide variety, with an excellent service, at the following prices :—

Breakfast and Lunch	1s. 4d. each.
Dinner	2s.

and these were the prices charged in the immediate pre-war period.

The preliminary expenses incurred in forming the Company were written off, plant, machinery and equipment were written down to £100, and reserve fund of £700 established. In addition, grants amounting to nearly £4,000 have been made to the Clubs' Union, Students' Club and the College, and over £1,000 spent on capital expenditure on kitchen equipment and furniture for the Students' Club. The profits on the sale of exciseable goods are credited to the Students' Club.

Owing to the dispersal of students to the Sector hospitals soon after the outbreak of war a serious slump took place, which resulted in the loss of nearly £500 during 1940, and it was necessary to utilise the reserve of £700 to meet this deficit. However, in spite of rationing, bombing and the small numbers in attendance at the Hospital an excellent service was maintained until the College was closed by enemy action in 1940. At this time the staff common room in the Medical School was immediately requisitioned, the Biology Laboratory converted into a temporary kitchen and still room, and meals were served within twenty-our hours of transferring the equipment and stores from the College. The staff laboured under great difficulties, but thanks to their co-operation and considering the facilities available, a good service and excellent meals were provided.

When the School returned to London the dining-room and kitchens were repaired to provide increased accommodation and every effort has been made to provide a cafeteria for quick-meal service; although certain accommodation is available for this purpose the great difficulty is to obtain the necessary staff. Staff difficulties have of late been an acute problem to the Board and in spite of repeated representations to the Ministry of Labour no priority for the employment of labour could be obtained. Wages have increased considerably (in some cases over 100 per cent. in excess of pre-war levels) and the cost of goods is much higher. As a result it has been necessary to increase the price of meals in order to maintain their quality. The Company's balance-sheet for the last financial year shows a net profit of £408, which represents only 8 per cent. of the gross receipts. It will be apparent, therefore, that to work on any finer margin of profit would make the Company financially unstable, so that any reduction in the price of meals is impossible in present circumstances.

The Students' Club Committee of the Board of Directors will welcome any suggestions which might be practicable in the interests of an improved service.

A list of grants made by the Catering Company to the Clubs' Union, Students' Club and College is set out below:—

Clubs' Union.			
General Expenses		£50 0 0	
Pavy Gymnasium		285 0 0	
Squash Courts		1,048 0 0	
Pavilion (H.O.P.) Extension		800 0 0	
Swimming Bath (proportion of repairs)		100 0 0	
Students' Club.			
Dining Room—			
Alterations, Decorations and Linoleum	£385 0 0		
Reading Room—			
Renovations	200 0 0		
Rent	600 0 0		
College Alterations	300 0 0		
		1,485 0 0	
College.			
New Calorifier		100 0 0	
		£3,868 0 0	

In addition, the Board has voluntarily accepted responsibility for the annual rent of £100 charged by the Governors of the Hospital for that portion of the College now occupied. This recurrent expense would normally have fallen upon the Student's Club.

Yours, etc.,

S. H. WASS,

Hon. Sec., Students' Club.

Guy's Hospital, S.E.1.

Sport

Rugby

GUY'S *v.* NEW ZEALAND SERVICES XV.

(*Played at H.O.P. on February 17th*, 1945.)

Although Guy's lost this game by 2 goals, 1 dropped goal, and a try (17 points) to 1 penalty goal and 2 tries (9 points), the team showed more promise than they had done for a long time.

The Services, playing with the wind in the first half, soon found gaps in the Guy's defence, and 2 fine tries by Hill and 1 by Hunter, 2 of which were converted by Crist, gave the Services a lead of 13 points, which decided the match. During this disastrous period Guy's were unfortunate to lose I. Hilliam through injury. During the later part of the first half Guy's began to show some fight at last, and the scoring was started by Jones, playing his first game since his injury early in the season, who kicked a splendid penalty goal.

A sporting gesture by the Services' captain brought M. P. O'Reilly on to the field at half-time as a substitute for Hilliam.

In the second half the whole trend of the game changed. The Services scored first by a fine dropped goal by Ridland, but this was followed by a stirring Guy's rally, which suggested that the old spirit was not dead. Pressure on the Services' line was rewarded and Kinder and Rean both went over from loose mauls for unconverted tries. It was a great shame that the three-quarters lacked the finish which would have added many points in this half, but this will come if more care is taken in passing and more energy exerted in ceaseless backing up of individual efforts.

The forwards went through a remarkable metamorphosis during the game, and the pack

that came off the field showed no resemblance to the pack that played for the first fifteen minutes. It will be good to see the whole team in such form that they go straight into the game and keep hard into it until the final whistle.

Boxing

INTER-HOSPITAL COMPETITION.

This competition, the first of its kind since the beginning of the War, was held at 61 Arch, Bermondsey Street, London Bridge, on Wednesday, February 14th, 1945, under the jurisdiction of A.B.A. The preliminary bouts had taken place at Guy's three weeks earlier, so semi-final and final bouts only were on the programme.

Of the semi-finals Guy's men boxed in six out of the eight contests. In the 9st. class R. L. Leader, of Guy's, encountered a very experienced opponent, A. Teuton, of St. Mary's, and the decision was awarded to the latter in the first round.

In the Heavyweights, M. W. Harber (Guy's), keeping his end up for the three rounds, was nevertheless defeated by M. Floyer, of "the London." With more confidence and experience Harber is likely to earn better success in future.

J. M. Pugh, in the 10st. class, afforded Guy's their first victory of the evening, when he defeated G. Bolt, of "the London," the bout being stopped in the third round. Bolt showed resilience and spirit, but he could not stand up to the power of Pugh's punches. In the other 10st. semi-final, R. Hart, of St. Mary's, beat C. Baker, of "the London," thus qualifying to meet Pugh in the finals.

In the 10st. 7lb. class S. F. A. Westgate (Guy's) overcame W. G. Barry (Middlesex) on points; the referee had to be consulted before a decision was made. This was a brisk bout and a good one to watch, but Westgate should remember to box rather than fight. The other 10st. 7lb. semi-final bout was between A. E. MacLachlan (Guy's) and J. M. S. McCoy, of St. Thomas's. McCoy was the more experienced pugilist of the two and he outboxed MacLachlan, who, nevertheless, put up a spirited fight.

As the results of an unfortunate draw, C. H. Kinder (Guy's) had to box R. D. Walshe (Guy's) in the 12st. semi-finals. The bout started evenly, both competitors defending well, and towards the end of the first round Walshe knocked his opponent down. In the next round Kinder asserted a superiority which he maintained to the end. This left him to face J. A. Reynolds, of St. Thomas's, who obtained a walk-over into the finals.

Guy's men took part in five out of the nine finals contests. In the 8st. 7lb. class, K. Gordon (St. Mary's) beat R. Clarke (St. Mary's).

In the 11st. 7lb. final, J. A. Shaw (Guy's) beat N. H. Porter (Guy's) in a bout that was stopped at the beginning of the second round. It was merely the power of Shaw's punches that gained him the decision, and he may find it of advantage to box more, especially against more experienced opponents.

In the 12st. 7lb. class, D. Miller (St. Mary's) overcame J. H. Garson (St. Thomas's).

At 9st. M. Mason (Guy's) did well to hold A. Teuton (St. Mary's) to a points decision, for the latter was an opponent obviously well tried in competitive boxing; Mason was a plucky loser, however.

J. M. Pugh won the 10st. weight for Guy's by beating R. Hart (St. Mary's) in a good even bout. While Pugh's left feint followed by a straight right to the head scored nearly every time, his backwards sway obviated Hart's superior reach to a great extent. At the end of the third round resort was made to the referee for a decision.

In final of the 10st. 7lb., J. M. S. McCoy (St. Thomas's) beat S. F. A. Westgate (Guy's) on points. This was a victory for McCoy's straight lefts, for though Westgate was aggressive to the end and got in several good "rights" to McCoy's body, he could never defend himself adequately against his opponent's blows. It was a strenuous bout and good to watch.

C. H. Kinder, in the 12st. class, won the final bout of the evening for Guy's, when his contest against J. A. Reynolds, of St Thomas's, was stopped by the referee in the second round The first round saw Kinder apparently fatigued by his previous bout; and Reynolds seemed to have the initiative. But following a few "wise words" from Mat Wells before the start of the second round, Kinder went into the attack with such vigour and success that the referee stopped the contest.

In the 11st. final A. Rizler got a walk-over against J. A. Richardson, of "the London." M. Floyer obtained a walk-over victory for the London in the Heavyweights.

At half-time the hon. secretary, Mr. J. H. E. Winston, entered the ring to speak a few words concerning the past deeds and future hopes of United Hospitals' boxing. He rendered thanks, too, to the Mayor of Bermondsey for patronage, to officials of the A.B.A. for their kind services, to the Civil Defence for the use of the hall, and to many other co-operators.

Mr. G. A. R. Winston, besides being a very effective master of ceremonies, was responsible for much of the organisation that rendered the competition possible.

To sum up, the following were the winners of the finals contests:—

8st. 7lb.—K. Gordon (St. Mary's).

9st.—A. Teuton (St. Mary's).

10st.—J. M. Pugh (Guy's).

10st. 7lb.—J. M. S. McCoy (St. Thomas's).

11st. 7lb.—J. A. Shaw (Guy's).

12st.—C. H. Kinder (Guy's).

12st. 7lb.—D. Miller (St. Mary's).

11st (walk-over).—A. Rizler (St. Mary's).

Heavyweight (walk-over).—M. Floyer (London).

UNITED HOSPITALS' BOXING TEAM *v.* OXFORD.

Flyweight.—K. Taylor (St. Mary's).

Bantam.—R. L. Leader (Guy's).

Feather.—(1) A. Teuton (St. Mary's); (2) M. Mason (Guy's).

Light.—(1) J. M. Pugh (Guy's); (2) S. Hulls (Westminster).

Welter.—(1) J. M. S. McCoy (St. Thomas's); (2) S. F. A. Westgate (Guy's); (3) R. Hart (St. Mary's).

Middle.—(1) C. H. Kinder (Guy's); (2) A. Rizler (St. Mary's); (3) M. P. O'Reilly (Guy's).

Light Heavy.—(1) R. Walshe (Guy's); (2) D. Miller (St. Mary's).

Heavy.—(1) M. Floyer (London); (2) R. Whitcombe (St. Mary's; (3) M. W. Harber (Guy's).

Sector 10—House Appointments

FEBRUARY 1ST TO APRIL 30TH, 1945.

Hospital	*Remaining*	*New Appointment*	*Transferred*
GUY'S	S. M. Hilton (B.2) B. H. Pentney. D. Q. Trounce.	P. R. A. May D. P. Nicholson. J. M. Thomas.	R. E. Irvine (B.2) (from Farnborough). M. W. L. Mutch (from Farnborough).
WILDERNESSE ..	R. C. W. Thompson.	N. K. Macrae-Gibson.	
JOYCE GREEN ..	W. H. Lillywhite (B.2).	D. O. Lloyd.	H. P. Merrick (B.2) (from Pembury). J. S. Ebsworth (from Southern).
PRESTON HALL ..	A. E. Gibbs.		
ORPINGTON ..	M. D. Keates (B.2). E. A. Wright. O. H. E. Williams.	H. Van Diggelem (B.2). D. P. Wheatley.	
FARNBOROUGH ..	P. Brightwell (B.2).	R. G. L. Brittain.	M. E. Evans (B.2) (from Pembury). G. J. Haas (B.2) (from Joyce Green)
PEMBURY	A. B. Dickie (B.2). I. Macdonald.	A. St. J. Dixon. E. G. Murphy. N. C. P. Watford.	
SOUTHERN ..	F. G. B. Dodd (B.2). L. W. Godfrey. E. D. C. Jones.	P. C. Leeson. H. J. Lewis (B.2).	
LEWISHAM	R. A. Allen (B.2).		
QUEEN MARY'S ..	W. C. Johnson (B.2).		

Hospital Information, etc.

Pass List

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

February, 1945.

PART I.—Surgery.

J. E. Attale
C. C. Bull
G. T. Crook
J. E. De Boudt
H. C. Goudge
W. D. Hannaford
C. M. M. Jenkins
W. O. King
J. B. Kirkwood
R. T. Lowein
P. C. Matthews
K. G. B. Pritchard
P. M. Stephens
A. J. Swann
G. Thompson
A. E. Trist
A. J. L. Wheatley

PART II.—Dental Surgery.

A. J. Bridge
A. C. Campbell
P. C. S. Campion
J. W. Coombs
P. Griffiths
N. S. McKie
C. S. Matthews
K. H. Sudell
G. Thompson
J. E. C. Weddup

UNIVERSITY OF LONDON.

THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.

February, 1945.

Pass.

R. F. Barclay
F. B. S. Barkworth
A. S. R. Cini
A. St. J. Dixon
H. A. Lane
P. C. Leeson
D. O. Lloyd
K. A. Macdonald
N. K. Macrae-Gibson
E. G. Murphy
D. P. Nicholson
D. T. H. Paine
N. J. Shah
N. C. T. Watford

Supplementary Pass List.

PART I.

M. M. El Shinnawi
B. D. Grant
J. O. Kelsey
P. R. Montgomery
K. A. Newton
D. O'Keefe
C. M. G. Pearson
D. J. Rudman
A. G. I. Stockley
D. M. Zausmer

PART II.

M. J. Blunt

PART III.

E. R. Arnold
D. E. M. Brown
K. A. A. Campbell
A. A. Cashmore
C. B. Clarke
D. Davies
N. R. Fenton
D. D. Forbes
J. S E. Gilbart
G. E. Griffiths
J. D. Huntley
M. B. King
W. R. Lee
J. W. Lewis
R. P. C. MacDonald
K. A. Newton
N. G. Nicholson
D. M. Zausmer

UNIVERSITY OF CAMBRIDGE.

The Degrees of Bachelor of Medicine and Surgery have been conferred on J. M. Thomas.

Deaths

HOPSON.—On February 26th, 1945, at Pinegrove, Crowthorne, Berks, Eva Kate, widow of Montagu F. Hopson, late Consulting Dental Surgeon, Guy's Hospital.

SHARPE.—On February 21st, 1945, at Roughlee, Longton, near Preston, Frederick Augustus Sharpe, M.D., B.S., D.P.H., Medical Officer of Health for Preston.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1478 *17th March, 1945* *Ninepence*

PASSIM

THE pre-clinical school has been back in London just under a year now, but their amalgamation with the students in the Clinical School has been so slight that they might as well still be in Tunbridge Wells. None but the most unastute observer could fail to be aware of the gap that exists between the pre-clinical and the clinical students at the Hospital, a gap which cannot be wholly explained by the different nature of their studies. Nor can this rift be explained by the plea that the newcomers have not yet had time to settle in to the Hospital routine, for this they undoubtedly have done, and by their energies they have revived the flagging social life of the Hospital. Their enterprise has given us plays, debates, talks and dances within the last few months, and their newspaper—*Pulse*—has thrived since its birth at the end of last year. The arrival of this newspaper was probably the first articulate effort of the pre-clinicals to assert their position in the Hospital and it essentially caters for them and not for the clinical students; it expresses their views and records the activities of their societies and of the games clubs; other items include their proposed war-cry and satirical attacks, often in verse (*sic*), against our guests from the Royal Free. It is self-evident that the *Gazette* does not fulfil the needs of the pre-clinical students; this is, to some degree, inevitable, for our circulation amongst anatomists, physiologists and biologists is but a fraction of our circulation amongst medical men. However, we have co-opted two pre-clinical members on the *Gazette* Committee recently and, with their able help, we hope to provide more of pre-clinical interest in the future.

The fault, if fault there be, for this disparity between clinical and pre-clinical students is not a matter of personalities, but seems to lie with the times. The difference in the relative ages of the two groups may play some part, and there certainly seems to be a difference in interests; but the gap must inevitably become less as more pre-clinical students graduate to the clinical course and consequently extend their friendships and propagate their views more widely.

TEACHING in the Hospital has been re-invigorated with the coming of Spring; the Medical School committee, possibly spurred on by various suggestions from members of the Hospital, have done much to improve the facilities at our disposal, which have necessarily become attenuated by the exigencies of the War. A fortnight ago we welcomed Mr. Gibberd back from the Forces, and his teaching rounds and ante-natal clinics on Thursdays are so enthusiastically attended that we have heard the small voice of an obstetric dresser raised in protest from the outskirts of the crowd as he fights for a glimpse of the patient.

Air-Commodore Conybeare has also resumed his teaching at the Hospital, taking the Thursday afternoon round in place of Dr. Idris Jones, who will be starting Friday afternoon rounds shortly.

WE must congratulate the First XV on their outstanding performance against St. Mary's a fortnight ago. This success has proved that the standard of Guy's rugger has in no way deteriorated and that what we lacked was the organisation which would get the best results from the material to hand. This deficiency seems to have been remedied and we look forward to a fine finish to what has hitherto been a disappointing season.

WE regret to announce the death of Mr. Harold Chapple, Senior Obstetric Surgeon to the Hospital. An obituary will appear shortly and a Memorial Service will be held in the Chapel on Tuesday, March 20th, at 1.45 p.m.

Clinical Aspects of Crime

By W. NORWOOD EAST, M.D., F.R.C.P.,

Special Consultant to the Royal Navy ; formerly H.M. Commissioner of Prisons, England and Wales, etc.

An Address delivered on May 23rd, 1944, before The Oxford University Medical Society.

(*Concluded*)

The importance of regarding criminal behaviour from the biological point of view is demonstrated by the fact that crimes can be considered in relation to the instinct which is operative, for its expression in man is often comparable with its mode of action in the lower animals. The student of criminal behaviour is chiefly concerned with the acquisitive, sexual, aggressive, parental and gregarious instincts, and the associated psychological reactions of the offender. Moreover, in the lower animals the instinctive urges sometimes seem to act with varying degrees of intensity in members of the same species, and it is a common observation that the influence of any particular instinct varies much in different men and women.

A perverted mode of instinctive activity is associated with some forms of crime, particularly those of a sexual character. As the term "perversion" is sometimes used loosely and without any precise pathological significance, it is well to regard it as a mode of action in which complete satisfaction of a particular instinct is sought and obtained without using the ordinary method of expression. It must be persistently indulged, preferably in reality, at any rate in phantasy, and must not be merely a substitute for a normal activity which for some environmental reason is difficult to obtain. The most frequent example in criminal cases, apart from homo-sexuality, is afforded by men who indecently expose themselves to women and young girls. Less frequently in cases of fetishism, in which, for example, an article belonging to a woman becomes an object of sexual attraction instead of the woman herself. Non-criminal perversions are, perhaps, most usually associated with the food-appetite, for example in some women who are pregnant; and the use of tobacco, chewing-gum and the like in men and women.

The condition of "pica" in animals is characterised by an irresistible desire to lick or gnaw unusual substances, or to eat disgusting material, and sometimes seems to be analogous to the perverted tastes of men and women who are mentally abnormal.

The fact that unusual behaviour may be the result of a past experience is common knowledge, and the fact that a crime may be similarly induced is generally recognised to-day. In considering the biological approach to crime it is interesting to note that Stainton refers to a shooting dog who invariably became hysterical in passing a small copse, and to a pony who never passed a certain cross-road without exhibiting evidence of extreme fear. It is difficult to believe that behaviour of this sort would arise, like some crimes, unless conditioned by a strong emotional experience in the past.

The foundations of character are based upon the inherited instincts and their accompanying emotions, and one of the most striking features of adolescent and adult offenders of both sexes is a failure to control instinctive action and allow the desire of the moment to outweigh future prospects. Situations often arise which result in crimes which could be avoided by the exercise of ordinary self-control, since the instinctive urge is generally no stronger than in non-criminal situations, and in some cases is markedly weaker. The power of control is often available but has not been exercised. To attain social behaviour it is necessary to learn and accept the traditions and conventions of the society in which we live, and this can only be done by the aid of personal contacts which become increasingly complex as we pass from the restrictions of the nursery to the wider surroundings of the home, the school and the outer world.

Although the development of character in youth depends largely upon what it receives from others more experienced, it is, nevertheless, true that even in maturity we can gain much in the further growth of our characters by association with others of the right sort. In other words, character formation is not necessarily static, although changes are fewer as age advances.

Every crime is a mental problem, and the observer who is concerned with the clinical aspects of crime must have a sound practical knowledge of psychological medicine. The first step is to determine the mental group, whether normal or

abnormal, to which the offender belongs, and then analyse the mental condition still closer and classify it according to its appropriate sub-group. It would lead us too far afield to do so here, but psychiatrists, psychologists, bio-chemists, biologists and others are actively engaged in efforts to elucidate the limitations and origins of the various groups and sub-groups. Thereby they assist in the prevention of crime, and the diagnosis and treatment of abnormal criminals.

Probably more than 80 per cent. of offenders in this country are mentally normal. Official statistics show that about one-half of 1 per cent. are certifiable under the Mental Deficiency Acts, and 1 per cent. are insane. The balance is made up of the subnormal, psychopathic personality and psychoneurotic offenders, perhaps in this order, but the proportions are undetermined and remain matters for future research. The psychopathic personality group has received less attention from psychiatrists than it deserves, but future investigations and the recently developed interest in its association with crime will certainly prove instructive.

The pre-clinical student has neither time, training or opportunity to study the mental abnormalities of his friends and acquaintances, but he can always acquire, by day-to-day observation, knowledge concerning their manner of thought and the variations of behaviour they exhibit and which appear to fall within normal limits. He is likely thereby to find himself in agreement with Freud's observation in *The Ego and the Id*: "The normal man is not only far more immoral than he believes, but also more moral than he has any idea of." If the science student finds a consideration of crime and criminals repugnant he should remember Bernard Hart's observation: "Whenever one encounters an intense prejudice, one may with some probability suspect that the individual himself exhibits the fault in question or some closely similar fault."

We estimate the mental condition of others by their conversation and conduct, and the term "normality" in this connection must be elastic since individual variations of thought and action, of intellectual ability, emotional reactivity and will-power are so extensive that we cannot disregard the fact that no one of us is normal except in relation to himself. Even so most men and women at some time or other are affected by love, sudden success, grief, disappointment and the like in a manner which causes them to react excessively and overstep their ordinary emotional threshold. Variations of intelligence and will-power also occur in ordinary persons who differ in these matters, not only among themselves, but in themselves at different times. Shakespeare emphasised this when Theseus declared that "the lunatic, the lover and the poet are of imagination all compact"; and when Troilus confessed that "sometimes we are devils to ourselves."

The association of crime with mental abnormality was exaggerated in the past when physical characteristics were recognised to be of comparatively little importance as crimogenic correlates, and truth-seekers turned to the mental aspects of criminality in order to satisfy their quest. Since acquisitiveness, sexuality, aggressiveness and other innate qualities must be controlled in a well-ordered society, punitive measures must be adopted if social approval and disapproval fail to maintain social security. Although it is clear that virtue is more easily attained by some, all of us are called upon to develop the social sense which puts the interests of the community before our own desires. Even when the lesson is learned and acted upon it may unexpectedly fail in times of stress. For example, the difficulties associated in everyday life with the War have not merely caused thefts and assaults by criminals during the black-out hours, but have caused mean-spirited civilians to buy black market goods for their own profit, and in other directions evade the necessary but irksome restrictions legally imposed upon each one of us in order to secure the safety and well-being of all. The war-time failure of those, who in ordinary circumstances are not anti-social and not given to indulge themselves at the expense of others, has sometimes demonstrated an unsuspected liability among people in favourable circumstances to become common criminals on slight provocation.

During the four years commencing March, 1934, East and Hubert carried out an investigation at Wormwood Scrubs Boys Prison to ascertain how far psychiatry and psychotherapeutic experience in the management and treatment of various forms of behaviour disorder due to psychotic or psychoneurotic illness, could be profitably applied to offenders serving prison sentences. We appreciated, of course, the fact that a psychological analysis may explain the origin of a crime whose motivation is otherwise obscure, and that the explanation, however accurate and scientific, does not necessarily excuse the crime. In all criminal cases there are two opposing factors—namely, the security of society and the interests of the criminal, and it is not without reason that the figure of Justice holds a sword in one hand and scales in the other.

The investigation was carried out on 406 selected males to determine their suitability for treatment, or to define more clearly the problems presented by the types of offenders who are not at present satisfactorily dealt with by the present penal system. Of this number 214 cases were considered to be suitable for psychotherapy.

In the result we concluded that psychotherapy as an adjunct to an ordinary prison sentence appeared to be effective in preventing or reducing the chance of future anti-social behaviour, provided the cases to which treatment was applied were carefully selected. Psychotherapy, however, is, and is likely to remain, a specialised method of treatment usefully applied to but a comparatively small number of disorders. It should only be recommended, whether the disorder of thought or behaviour is likely to lead to anti-social action in the future or not, if previous experience shows it to be necessary, likely to be effective and, considering the particular circumstances of the case, advisable. Young, referring to the investigation, rightly states that the question of suitability for psychotherapy cannot be based upon the nature of the crime alone, or on any associated psychological state, but must remain a matter for individual study, and therefore the number of cases likely to benefit by it cannot be predicted from criminal or medical statistics.

There can be no doubt that psychotherapy applied to young persons with criminal tendencies arising from constitutional mental abnormality and unfavourable environmental causes is likely to materially prevent the establishment of criminal behaviour in suitable subjects. In some cases it may be usefully employed as an alternative to punishment; in others it seems to be most effective when it is associated with punishment.

Apart from adverse psychological and environmental factors regard must be paid to the possibility that a spiritual conflict may be the cause of unusual behaviour, and that it must sometimes be resiolved before the patent becomes socially adjusted. The psychiatrist meeting this situation, whether criminal or non-criminal issues are involved, must be adept in the science and art of his profession. Indeed, I have no doubt that in dealing with many criminals the artist attains more reliable results in the diagnosis and treatment of accused persons than the scientist lacking in imaginative insight and frank sympathetic fellowship. In the words of Sir Thomas Browne, to which I have already referred, he must possess " a tunable disposition " in order to harmonise with the frailties and difficulties of his patient.

Those of us who are concerned with criminals, and in propagandising the medical aspects of crime and the importance of medical treatment in suitable cases, have no sympathy with uninformed enthusiasts who affirm that the adult criminal, as such, requires medical treatment and not punishment. As I have already stated, crime is not a disease, it is not usually a symptom of disease, and to declare that the criminal necessarily requires the same medical care as any sufferer from mental disorder confuses the issue, and antagonises those whose support is necessary if we are to go forward in the scientific treatment of crime. It is, moreover, idle and ungenerous to disregard the vast amount of successful work which is being done in this field by those who are not scientists. For example, offences due to alcohol addiction were at one time matters of serious and constant importance at courts of assize, as well as in courts below, and the prevention and cure of alcoholism and the prevention of alcoholic crime by medical means was comparatively insignificant. Widespread betterment, however, was brought about by legislation altering the hours when drink could be purchased and by introducing social improvements in other directions. They entirely overshadowed the occasional success of medical treatment. Granting. too, that most alcoholics suffer from nervous disorders, and that psychiatrists often fail to amend the psychopathic conditions underlying many cases of crime and drunkenness, there is much to be said for doubting whether legal punishment is altogether useless in this type of case, and some others of a quasi-medical nature. Hall believes, and many will agree, that we must recognise the fact that there are distinctive legal goals which may be at variance with scientific dictates, otherwise medical discoveries and propagandisation may do more harm than good.

I do not propose to consider the question of criminal irresponsibility due to insanity. But when medical criticisms of the criteria of legal responsibility are proferred with alternatives I am sometimes reminded of the gradual destruction of ecclesiastical influence in the criminal courts, to which I have already referred. I am also reminded of the fact that psychiatry is admittedly a very difficult and comprehensive subject, and although it is making considerable progress in many directions, is still in its adolescence.

CLINICAL ASPECTS OF THE FUTURE.

As I see it, the clinical aspects of the future will be related to research by psychiatrists, psychologists, bio-chemists, laboratory technicians, social workers, educationalists and others. It may be hoped that some of this work will be carried out at psychiatric centres, the offenders attending as out-patients; and some at the special penal institutions I have envisaged elsewhere.

It may be clear that a sentence of imprisonment passed upon an offender, who, although mentally abnormal, is not certifiable under the Lunacy or Mental Deficiency Acts, is far too short for any concurrent medical treatment to be effective. Nevertheless, the public will not support the imposition of a longer sentence than is appropriate in ordinary circumstances merely to enable medical treatment to be continued whilst the offender is in custody, although it is certain that further treatment will be avoided when he regains his liberty. Therefore, in addition to studying crime and criminals we must endeavour to present the scientific view of crime to the public when opportunity arises, so as to enlist their help in solving some of the dilemmas which arise in connection with treatment.

CONCLUSION.

We can hardly fail to believe that there is a considerable number of undetected criminals in the general civilian population who are never investigated scientifically because they evade arrest. In fact, we do not know to what extent our ideas of normality and abnormality in connection with crime would be modified if reseasch workers could study these men and women. But from the catastrophic results of the present war, as well as the war of 1914–1918, emerges the certainty that more people are liable to suffer from mental disorders than was sometimes supposed, and more normal people are liable to commit crime in war-time than in times of peace. Mental disorder and crime have this in common—they often depend upon the balancing of the constitutional make-up of the individual and the stresses to which he is subjected; upon the biological forces with which he is endowed and the environmental factors which he may, or may not, be able to control.

The investigations of earlier observers should encourage those of us who follow with our researches of to-day. Phrenologists, anthropologists and other workers, whose views on criminals and the causation of crime have been falsified by the light of subsequent knowledge, command our respect for their honesty of purpose, untiring diligence and unswerving patience and courage. As pioneers cutting their way through jungle and forest they could not always see ahead clearly; they often made false steps and sometimes viewed a false dawn, and we students of to-day often mistake the road and dally with non-essentials. Osler stated that "the true student possesses in some measure a divine spark . . . an absorbing desire to know the truth, unswerving steadfastness in its pursuit, and an open, honest heart, free from suspicion, guile and jealousy." That was finely said. May each one of us live up to it, finely, throughout life.

REFERENCES.

Bagot, J. H. Juvenile Delinquency. London, 1941.
Baldie, A. *Med. Press and Circ.*, 206, 240. 1941.
Blumenthal, F. *New York State Med. J.*, 41, 1749. 1941.
Browne, Sir T. Religio Medici (Pt. II, Sect. VIII).
Burt, C. The Young Delinquent. London, 1925.
Cathcart, E. P., Hughes, D. E. R., and Chalmers, J. Physique of Man in Industry London, 1935.
East, W. Norwood. Art. Physical Factors and Criminal Behaviour. Mental Abnormality in Crime. London.
——— *J. Ment. Sci.*, 47, 137. 1901.
———, Stocks, P., and Young, H. T. P. The Adolescent Criminal. London.
——— and Hubert, W. H. de B. The Psychological Treatment of Crime. London, 1939.
Ellis, Havelock. The Criminal (5th Ed.). London, 1914.
Feversham, Lord. Report of Committee. London, 1939.
Galton, F. Inquiries into Human Faculty. London, 1883.
Goring, C. The English Convict. London, 1913.
Hall, J. *J. Crim. Law and Criminal*, 32–297. 1941.
Hart, Bernard. Psychology of Insanity. Cambridge, 1936.
Hooton, E. A. The American Criminal (Vol. I). Cambridge (Mass.), 1939.
Horder, Lord. Health and a Day. London, 1937.
Hrdlicka, A. *J. Crim. Psych.* 1–87. 1939.
Kenny, C. S. Outlines of Criminal Law. Cambridge, 1909.
Kranz, H. Zebenschicksalle Krimineller Zwillinge, 1936.
Kretschmer, E. Physique and Character. (Trans. by Sprott W. J. H.) London, 1925.
Lange, J. Crime as Destiny. (Trans. by Haldane, C.) London, 1925.
Lott, G. M. *J. Crim. Law and Criminal*, 30–692. 1940.

Osler, Sir W. The Student Life. Æquanimitas. London, 1939.
Rosanoff, A. J. and I. A., and Handy, L. M. *J. Crim. Law and Crim.* Jan.–Feb.., 1934.
Ryle, J. Natural History of Disease. London, 1936.
Stainton, H. *Brit. J. Ineb.* 41–24. 1943.
Stephen, SirJ. F. Hist. Criminal Law of England (Vol. II). London, 1883.
Stumpfl, F. Die Ursprunge des Verbrechens dargestelt am Lebenslauf von Zwillingen. Leipzig, 1936.
Walter, Grey, W. Art. Electroencephalography. Recent Progress in Psychiatry. London, 1944.
Willemise, W. A. Constitution Types in Delinquency. London, 1932.
Young, H. T. P. Appendix in Psychol. Treatment of Crime (East and Hubert) London, 1939.

Reviews

Manual of Diseases of the Eye. By MONTAGUE HINE, M.D., F.R.C.S. 9th Edition. Published by May & Worth, Ltd.

THE ninth edition of May and Worth's text-book by Mr. Montague Hine is a very readable book, and a most useful one for the undergraduate and general practitioner. It is not too cumbersome, and it does not overstress the debatable and advanced theories and conditions. There is a very useful section at the commencement of each chapter on the anatomy and physiology of the different structures of the eye, and the illustrations, which are numerous, are good and clear.

The text has been brought up to date in the treatment of disease by sulphonamides, though progress in this and in treatment by penicillin is developing almost too rapidly for any book to keep pace with it.

Virus disease, allergy and vitamin defects are all dealt with reasonably clearly.

Refractive errors and squint are particularly well described, and the different Service visual requirements are brought up to date.

The book can be thoroughly recommended as a useful one for study by students and for reference after qualification. O. G. M.

Text-book of Surgical Treatment. Edited by Professor C. F. W. ILLINGWORTH, M.D., Ch.M., F.R.C.S.E. Second edition. Published by E. and S. Livingstone, Ltd., Edinburgh. Pp. 564. *Price* 30*s.*

THE original purpose of this text-book was to provide the senior student with an approach to surgical treatment which was at the same time both wide in outlook and yet sufficiently detailed to be of practical use. Descriptions of major operations and the more technical aspects of surgery are therefore deliberately avoided, the aim of the editor and his contributors being to refrain from the production of another text-book of operative surgery. As they wisely remark: "Surgical treatment implies very much more than the performance of a surgical operation," and we accordingly find the emphasis laid more on principles and indications.

The changes in this the second edition are minor apart from the chapter on burns, which has been entirely re-written, and the inclusion of some new colour illustrations. This book forms a very valuable and useful addition to the two other text-books with which Professor Illingworth's name is associated. J. P. M. B.

"*Doctor in the Making*": *or the Art of being a Medical Student.* By ARTHUR W. HAM, M.B., and M. D. SALTER, M.A., Ph.D. Medical Publications, Ltd. Pp. 120. *Price* 9*s.* 6*d.*

THE publication of this book is the outcome of a series of investigations of an advisory committee for first year medicals at the University of Toronto. The subject-matter of the book is concerned with the common obstacles to success which the authors, as members of this committee, discovered in their researches. Fortunately, the authors, one of whom is the Associate Professor of Anatomy and the other a practising psychiatrist, have not neglected the more positive side of their duty, and it is therefore refreshing to see such concern expressed for the development of the student's mind.

The book is divided into three parts—(1) Motivation and Equipment; (2) Enemies of Success and How to Defeat Them; and (3) The Responsibilities of a Medical Student.

At first glance the book appears to have the makings of a popular manual of business psychology with its continued references to "$\frac{\text{realisations}}{\text{demands}}$ ratio," "your child-self," "a fifth-column in your mind," but if the reader realises that this is probably a reaction of annoyance to the truth of some of the statements, all will be well.

Of course, the authors are wise enough to realise that no single pattern of studies can be laid down for an individual student and they are merely concerned with pointing out the commoner points of failure and the enumeration of general principles in order to remedy the fault. Their chief concern is to try and teach the student "to learn how to learn" and to make the most of his very full curriculum. The chapter on "Your Child-self" is particularly valuable in view of the young age of entry to medical schools at present.

In conclusion, it is difficult to understand why a book of some 120 pages should cost 9*s.* 6*d.*, but apart from this every first year medical should read this book.

J. P. M. B.

Correspondence

WOMEN STUDENTS.

To the Editor of the GAZETTE.

SIR,—In a recent issue you had occasion to refer to a remark made in the House of Commons by a member who is both a woman and a doctor. This lady, whom you generously, if rather flatteringly, described as eminent, you report as having expressed herself to be looking forward to the day when hospitals like Guy's and Bart.'s would be compelled to take in women students.

That black day appears to be disturbingly nigh. It is, perhaps, a comment on our times that its approach is to be hastened by a piece of rather vulgar financial blackmail. Any medical school unpersuaded of the advantages of co-education is to have its university grant stopped. No doubt a method of this kind may be justified in enforcing the popular will, but it is by no means clear that in this matter the will is popular. After all, the members of the Goodenough Committee, on whose recommendation this proposal was founded, are not necessarily in all their judgments entirely unwanting, despite the high praise well earned them by their Report.

Before changing any system, most reasoning people would require evidence that the new alternative would be a step of improvement. Does that evidence exist? Is it true that the alumni of those medical schools which have practised co-education are of better quality than their presumably less fortunate colleagues from the more monastic schools? For himself each will answer, but unless the evidence is favourable beyond a peradventure there can be no virtue in enforcing the principle that *all* schools must accept co-education. Is there to be no variety left in life and even medical education to become standardised—in short, "utility"? Here, then, lies the great objection to the Goodenough recommendation: that not one single school, unless it can afford to forego the university grant, may offer a training in medicine to those who prefer to do their day's work in the company of their fellow-men alone. That is the crux of this issue; all to a pattern, individuality for none.

Notwithstanding the mass of arguments valid for and against the proposal, there is a large number, in the view of many a large majority, of men who just do not want to be in the presence of women for the whole of their working day as well as in the hours of recreation. This want is something basic; it is fundamental; it comes from a man's bones. Why, he may be unable to say, but he knows it is there like his appetite. And he thinks of a woman as a complement to his life, not as a round-the-clock concomitant. It is, of course, an unfortunate fact that the man who holds these views is labelled by those who misunderstand the right use of English words as reactionary, unprogressive—in a word, rather a monster. As well condemn the man who says he likes jam but not marmalade, though he doesn't know why.

A plea may be put: the woman in medicine has come to stay. That is certain, and she must be given every opportunity to receive as good a training as a man has open to him. This at least can be done even though the more natural endowments for this career which the Creator has seen fit to withhold can hardly be made up to her by a House of Commons vote. More medical schools might therefore be founded in association with some of the great non-teaching hospitals. In parentheses it may be

observed that the London County Council seems to believe itself ready to take responsibility for medical education as well as its onerous work in connection with the disposal of sewage, licensing and other multifarious duties.

Then for those who prefer to be in constant contact with women during their course, many most excellent schools are already in existence. But it appears that there is to be no place for the student who has a taste for celibacy between breakfast and afternoon tea.

In conclusion, would Guy's be any the worse for opening its doors to women? None can foretell. What is certain is that *a priori* it would be different. To live and to learn with men in that robust atmosphere upon which so many old Guy's men have come to look back in love and gratitude is surely nothing shameful nor yet unnatural. At times it may be a little rough, perhaps a trifle coarse, but it makes doctors who are the more sensitive and not less so.

The claim that since men and women must work together as colleagues they must needs be educated together does not bear close examination. It may be ventured that unless a man, qualified or unqualified, be either a boor or a bounder he will find little difficulty in associating amicably with a woman blessed with a sense of humour and not given to too much talking.

This, then, is the real core of the problem, appreciated neither by the mental misogynist nor the humbug with the higher centres of a hermaphrodite.

Yours, etc.,

R. T. HINDE.

42, Trinity Church Square, S.E.1.

WOMEN STUDENTS IN MEDICINE.

To the Editor of the GAZETTE.

SIR,—The annotation by "Passim" on women students in medicine (February 17th, page 35) does not make altogether clear the position with regard to women at the present time. In London the position is, of course, less satisfactory than in the provinces. There are about 12,500 medical students in Great Britain, and of these *not more than a fifth are women. It is estimated that of the 5,000 students at the* London schools no more than 600 are women.

At most provincial schools women are eligible for admission on the same terms as men, but London women have only four schools from which to choose—the London School of Medicine for Women, which accommodates 400 students and admits about 100 a year; the new West London Medical School, which admits women only and accepts 24 students annually; University College Hospital Medical School, which admits 12 women annually; and King's College Hospital Medical School, which also admits 12 women annually.

It is appropriate to recall that a committee of seven members was appointed in February, 1943, by the Senate of London University, to inquire whether it was desirable to provide better facilities for women medical students. A year later the committee reported to the Senate, six of the seven members recommending that all the London medical schools should be open on equal terms to the two sexes. The Senate has approved the majority report of the committee and there is reason to believe that the medical schools will fall into line. It is maintained, however, that the policy cannot be carried into full effect for some years, in view of practical difficulties, including provision of new accommodation and facilities. In the meantime, therefore, London women are restricted in their opportunities and in their choice of schools.

There is no doubt, however, that the need for women doctors is growing and will increase. Men and women should have equal opportunity, not only to enter medicine, but also in every type of practice which is open to the registered practitioner. The Senate of London University have acted on this sound principle in recommending that all London medical schools should be open on equal terms to the two sexes. In addition, Mr. Willink, Minister of Health, stated in Parliament on January 18th that "the Government accepted the principle of increased grants for medical education and shared the views expressed in the Goodenough Report on the importance of affording to women equal opportunities to those enjoyed by men for medical training. The Government had therefore decided that future payments of grants to medical schools should be conditional on the adoption by the school of the principle of admitting a reasonable proportion of students of both sexes." The outcome is that men and women will eventually work side by side at all London medical schools.

So much for undergraduates. With regard to registered practitioners, the number of names on the Medical Register exceeds 60,000; of these over 8,000 are women. Though as a general rule there is still some bias against women in certain branches of medicine, the time is passing, if it has not already passed, when these prejudices will hinder the status of the woman doctor.

Both sexes in the role of medical adviser should be in possession of those simple endowments of personality, sympathy, and understanding together with scientific knowledge and equipment which make for success in medical practice. The woman doctor in possession of these qualities can engage in any type of practice for which she feels herself suited by aptitude and interest. While there are women engaged in private practice, both general work and the specialties, and in the health services of this country and of others abroad, it appears that they have particular advantages in certain forms of practice, such as school medical inspection, child welfare and midwifery. They have also proved their worth as anæsthetists.

Yours, etc.,

GEORGE R. W. N. LUNTZ.

Guy's Hospital, S.E.1.

BLACKMAIL.

To the Editor of the GAZETTE.

SIR,—It is a matter of some urgency that Guy's should formulate its attitude towards the inclusion of women students into the Medical School.

When this question was last raised the hitherto "apathetic" students of Guy's took the matter very seriously, and heated discussions took place all over the Sector. By clear majorities Guy's, Farnborough and Tunbridge Wells voted against the feminine invasion. We had scotched the snake; unfortunately it appears to be far from dead.

It is suggested that Government grants to the Medical Schools should be conditional to their including a fixed number of female students within their precincts. This is blackmail of a very crude order, and is not to be tolerated.

Let the matter once more be put to the common vote, and let the results of that vote be acted upon with firmness.

Yours, etc.,

R. G. WATSON.

Guy's Hospital, S.E.1.

MEDICAL CO-EDUCATION.

To the Editor of the GAZETTE.

SIR,—With all due respect to the author of "Passim" of February 17th, 1945, his argument as regards the medical education of women would carry much greater weight if, rather than adopting an all-wise attitude of "Take it from me; I know it does not work," he were to let us know just why the soil of London should be so particularly unsuitable for medical co-education.

Yours, etc.,

MICHAEL KUGLER.

33, Sandringham Court, London, W.9.

CARE OF LAWNS.

To the Editor of the GAZETTE.

SIR,—Now that the Park is again lit at night I venture to suggest that the chains round the lawns should be tightened or renewed, and that people should once more be discouraged from using the lawns as pathways. In this way the lawns may once more be covered by grass. If members of the Hospital are lacking in co-operation, might I suggest that notices be placed on the verges of the lawns in order to serve as a reminder?

Yours, etc.,

W. VAN 'T HOFF.

Guy's Hospital, S.E.1.

"PENNYCILLIN."

To the Editor of the GAZETTE.

SIR,—The ancients called the tail "penis" (Cicero). From "penis" comes "peniculus," the little tail or brush (compare the fox's brush). From this, again, "penicillum," a still smaller tail or painter's brush. Why, then, do men persistently say "pennycillin" or even "p'nissylin"? After all, Sir, the drug is important; the length of the "e" in its verbal progenitor is well known; and we ought to pronounce it in the right way. I suggest that henceforth we do.

Yours, etc.,

H. ST. H. VERTUE.

Orpington.

GUY'S HOSPITAL FENCING CLUB.

To the Editor of the GAZETTE.

SIR,—May I claim the use of your columns to appeal for equipment for the Fencing Club? This club, a part of the Pavy Gymnasium, has fallen into inactivity during the years of war and an effort is now being made to restart it. Fencing equipment is both expensive and difficult to obtain, and while we hope to obtain a certain amount, it would be a great help if any old Guy's men who have fencing gear for which they have no further use, would either present it or lend it to the club.

Any such equipment should be sent to:—The Fencing Club, c/o The Secretary, Medical School Office, Guy's Hospital, S.E.1; and will be put to good use.

Yours, etc.,

RICHARD NEVE,

Guy's Hospital, S.E.1. Hon. Sec., Fencing Club.

Medicine Extraordinary

EXAMINER (referring to pulsating tumour protruding from right side of patient's sternum): "And what further investigations would you perform?"

Candidate: "I should do a biopsy, sir."

Examiner: "And how would you treat shock?"

Candidate (slightly nervous): "Coffee and hot blankets per rectum."

Examiner: "What animal would you cite to illustrate the differences of action of atropine?"

Candidate (confused and Australian): "Well—er—the kangaroo, sir."

Examiner: "Come, come, come now! What about the rabbit, shall we say?"

Candidate: "Come, come, come, sir! What about my kangaroo?"

Sport

Rugby

GUY'S *v.* COVENTRY.

(*Played at H.O.P. on February 24th*, 1945.)

The visit of Coventry to Honor Oak Park did not attract such a large crowd as expected, but this may have been due to Guy's poor performances this season. It turned out, however, that the Hospital found a new lease of life and thoroughly extended the powerful Midlands side before admitting defeat by 1 goal and 3 tries to a try.

Guy's carried play to Coventry's line from the kick-off, but were forced back and, in the very first minutes, M. C. Jones, the Coventry scrum-half, crossed for an unconverted try. The Hospital hit back, and D. G. Jones kicked neatly to touch after Willcock had broken through, but Carton-Kelly had the misfortune to give a forward pass when an opening looked possible. Coventry had a chance from a penalty, but Wright's kick went wide and, keeping up a hot attack, Coventry were stopped in turn by Billingham and Gray with neat touch kicks. D. G. Jones went low with a penalty kick, and at this stage Brittain was prominent in preventing Coventry opening the play for their backs. Preece was always a great danger and made an electrifying run, dodging and swerving past four Guy's men, which carried him to the "25" line, only to finish with a forward pass. Coventry had another chance when Sidwell gave Sparkes an excellent pass but he was collared before making much ground.

Guy's had a really brilliant round of passing, which ended in D. G. Jones kicking too strongly over the line for a drop-out. Once more Guy's were beaten in the line-out and Preece found himself in a position to go clean through our defence to send Sidwell in for an unconverted try.

On the restart Guy's carried play to Coventry's "25" by means of sound forward rushes and accurate passing between the backs, which compelled Pateman the Coventry full-back, to clear under pressure. First, Brittain and Carton-Kelly, then Willcock, broke away, and Billingham was unlucky to be caught by the ankle following a fine run of forty yards, which took him close to Coventry's "25" line. Over anxiety by Guy's gave away two penalty kicks which proved abortive, and the Guy's defence did extremely well in surviving some heavy pressure. Eventually, M. C. Jones, again from a line-out, gave Preece another chance which that player used with exceptional skill in making an opening for Sidwell to cross for a try, and Newbold converted. Preece was again in the picture with a deceptive swerve and an accurate pass for Wright to score, but the kick failed.

Dwyer raised Guy's hopes when he kicked to the full-back and collared him in possession. The Coventry pack recovered, but the ball went loose on their line and from the scramble the referee awarded Guy's a try, officially given to Hilton, but Brittain, Batty-Shaw and Willcock were all there. Thus encouraged, Brittain and Batty-Shaw led a grand rush to the Coventry line and no-side was called with Guy's still pressing.

A word of praise must be given to M. P. O'Reilly and D. F. Potter, the "A" XV second row pair, for the creditable part they played against such formidable opponents.

GUY'S *v.* ST. MARY'S.

(*Played at H.O.P., Saturday, March 3rd*, 1945.)

St. Mary's Hospital were beaten by a dropped goal and 2 tries to nil. That this result was the biggest rugger sensation of the season is undisputed and, moreover, it was thoroughly deserved, as Mary's most sportingly admitted after the game.

This victory was brought about by excellent team work, but only after a hard and gallant struggle. The forwards laid the foundation by their all-round superiority. A. Batty-Shaw led the pack brilliantly. We had most of the ball from the scrums, due to C. H. Kinder's excellent hooking. R. G. L. Brittain and P. S. Carton-Kelly completely disorganised the combination between V. Morris and N. M. Hall, and the work of D. F. Potter and R. A. Dean and C. Vidot in the line-outs and the loose was a revelation, whilst A. G. MacCallum excelled as a solid scrummager. R. D. Willcock, captain for the day, gave G. P. Billingham an excellent service, which the latter turned to good account by constantly feeding the backs, and it was here that the accurate handling and clean passing by D. G. Jones, P. J. Dwyer, and N. K. Macrae-Gibson carried Guy's to frequent scoring positions. W. Selley was not so prominent as his colleagues. He had few chances to shine in attack, but his tackling of the full-back in possession was good. B. M. Gray, the full-back, was never flustered, and his tackling and kicking under pressure proved that this position is in safe hands.

Guy's kicked off and immediately obtained a footing in Mary's half, but when Mary's relieved the pressure B. M. Gray sent them back with a long touch kick, which was followed by Mary's being penalised from which D. G. Jones just failed with the kick. Guy's kept Mary's penned in their own half, but suddenly B. M. Gray brought off a grand tackle to prevent a Mary's break through. Mary's efforts to reach our half were frustrated by some grand tackling, and by the combination of R. D. Willcock and G. P. Billingham, with a quick pass out by the former and two excellent kicks to touch by the latter.

St. Mary's were compelled to touch down for a drop-out from a movement which nearly resulted in Guy's scoring, but N. M. Hall made a deceptive run which ended in our "25." R. A. Dean next came into the picture with a break away from a line-out, which ended in W. Selley being tackled, but once again Mary's launched an attack, only to be penalised for an infringement, and R. W. Watson was neatly tackled following a dangerous run by N. O. Bennett and N. M. Hall.

Guy's then penetrated into Mary's territory with a grand run by N. K. Macrae-Gibson, who could not pass his opposite number, but P. J. Dwyer kept up the attack with a strong kick to Mary's "25," and B. M. Gray's coolness further contributed to the power of attack. Half-time arrived with no score.

Guy's started the second half with an exciting dash to Mary's "25." G. P. Billingham kicked ahead and Mary's touched down, and D. G. Jones broke clean through the St. Mary's defence, only to be caught by N. M. Hall a few yards from the line. N. K. Macrae-Gibson brought off a grand tackle when preventing C. K. Ewart taking advantage of a pass from A. Venneker, but Guy's were now well on top with some perfect passing in which all the backs combined, and G. P. Billingham, receiving an accurate pass from R. D. Willcock, dropped an excellent goal, which sent Guy's supporters wild with delight.

The period which followed was critical as, in succession, N. O. Bennett, N. M. Hall and P. R. G. Graham endeavoured to break through, but forwards and backs set up a solid defence. G. P. Billingham and B. M. Gray both got in good kicks to touch, and R. A. Dean had a dangerous run which definitely worried Mary's. N. K. Macrae-Gibson had a wonderful burst on the line only to run into a solid tackle; the ball went loose, and eventually reached P. S. Carton-Kelly, who ran in for an unconverted try and, just as the cheering had died down, N. K. Macrae-Gibson passed inside to D. G. Jones, who had P. S. Carton-Kelly with him to touch down from the final pass under the posts.

Hospital Information, etc.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

February, 1945.

Medicine.—J. C. Matthews.

Midwifery.—H. Freeman, J. C. Matthews.

Papers by Guy's Men

Hugh Barber. The Effects of Trauma, Direct and Indirect, on the Heart. *Quart. J. Med.*, 1944, **13**, 52.

Stanm, T. T. Excision of the Proximal Row of the Carpus. *Proc. Roy. Soc. Med.*, 1944, **38**, 74.

Layton, T. B. The Common Cold. *Practitioner*, 1945, **154**, 45.

Hopkins, P. Aspirin Poisoning. Report of a Case. *Lancet*, 1945, i, 145.

——— The Septic Finger and Industrial Absence. *J. Indust. Welfare*, 1944, **26**, 78.

——— The Management of Minor Injuries and Infections of the Hand. *Nursing Mirror*, 1944, **70**, 159.

Blockley, C. H. A Large Maxillary Dentigerous Cyst. *Brit. Dent. J.*, 1945, **78**, 108.

Vale, W. A. Fracture of Apices of Upper Incisors. *Ibid.*, 109.

Cole, Percival. Inguinal Hernia in the Merchant Navy. *Brit. Med. J.*, 1945, i, 296.

Knott, F. A. Blood Transfusion in Practice. *Dental Record*, 1945, **65**, 63.

Boness, W. L. Reflection. *Brit. Dent. J.*, 1945, **78**, 129.

Shay, H. B., and Another. Association of Local Factors with Gingivitis. *Ibid.*, 135.

Matthews, E. Soft Resin Lining for Dentures. *Ibid.*, 140.

Henderson, R. L. V. Case of Osteomyelitis of the Mandible treated with Penicillin. *Ibid.*,, p. 144.

Change of Address

E. A. Adams (Miss), 287613 Q.A.I.M.N.S. (R.), 61st British General Hospital, P.A.I. Force.

J. W. Drury, Surg.-Lt. (D), R.N.V.R., H.M.S. *Bambara*, c/o G.P.O., London.

E. B. French, Major, R.A.M.C., 24th British General Hospital, Bangalore, West India Command.

E. C. Hughes, O.B.E. (Mil.), Grove Cottage, Hadlow Road, Tonbridge, Kent. (Tel.: Tonbridge 582.)

G. MacVicar, Surg.-Lieut., R.N.V.R., H.M.S. *Blankney*, c/o G.P.O., London.

A. H. Mayne, Major, R.A.M.C., H.Q. 202 Area, S.E.A.C.

O. Plowright, W/Cmdr., R.A.F.V.R., No. 4 R.A.F. General Hospital, C.M.F.

J. W. Robb. Lieut., R.A.M.C. (318058), 6th W.A. Field Ambulance, S.E.A.C.

Min. Sein, Lt.-Col., I.A.M.C., A.D.M.S. Hdqrs. C.A.S.C. (B), S.E.A.C.

Eric Smith, Major, R.A.M.C., O/C No. 1 Mobile Medical Unit, C.M.F.

W. G. Tillman, Major, R.A.M.C., 114 B.G.H., India Command.

A. B. Wayte, Major, R.A.M.C., 26, Hallgate, Doncaster, Yorks.

C. J. Zerny, Surg.Lt., R.N.V.R. H.M.S. *Termagant*, c/o G.P.O.

C. Ziervogel, M.R.C.S., L.R.C.P., Stellenbosch, South Africa.

Appointments

Hugh R. W. Franklin has been appointed Anæsthetist to the Thoracic Surgery Unit for the South-West Region.

Dr. Geoffrey Marshall has been elected Vice-President, and Mr. R. C. Brock to the Executive Council, of the Association for the Study of Diseases of the Chest.

The Services

Mentioned in Despatches.

Captain F. W. Rushby, A.D. Corps.

Sqdr.-Ldr. J. A. R. Smit, R.A.F.V.R.

Wounded.

Captain S. D. Stock, O.B.E., R.A.M.C.

Killed in Action.

Captain E. S. Walmsley, General List.

Awards

O.B.E. (Military Division).

Lieut.-Col. S. C. H. Lane, R.A.M.C.

Births

CLOKE.—On February 14th, 1945, at Quarry Place Nursing Home, Shrewsbury, to Dorothy (née Cross), wife of Ernest J. Cloke—a daughter (Marian Spencer).

CORFE.—On February 14th, 1945, at St. Matthew's Nursing Home, Northampton to Dare (née Bailey), wife of Roger J. H. Corfe, Captain, A.D. Corps (B.L.A.) —a daughter.

CHASE.—On March 5th, 1945, to Margaret (Peggy) (née Wilson), wife of Dr. G. H. G. Chase, West Limes, Priory Road, Stamford —a daughter.

KARK.—On January 3rd, 1945, to Lorna, wife of C. V. Kark, S/Ldr. (D) R.A.F., at 35, Drumsheugh Gardens, Edinburgh—a son (Alan David).

LACEY.—On February 3rd, 1945, to Joy, wife of G. Kenneth Lacey, Lieut.-Cmdr. (D), R.N.V.R.—a daughter (Rosemary Ann).

LYNE.—On February 10th, 1945, at Cliff Nursing Home, Penzance, to Ada Lillian, wife of W. H. Lyne, L.D.S., of the School Dental Clinic, Penzance—a son (Colin Gwaynten).

MAC FARLANE.—On February 3rd, 1945, at Longfield, West Cross, Swansea, to Sheila, wife of D. W. MacFarlane, Ft.-Lt., R.A.F.V.R.—a daughter.

MAC MANUS.—On February 10th, 1945, at Guy's Hospital, to Fiona (née McAlpine), wife of Niall MacManus, Surg.-Lieut., R.N.V.R.—a son (Nicholas).

MALLESON.—On February 14th, 1945, at Guy's Hospital, to Angela (née Lake), wife of Montagu Malleson, Ft.-Lt. R.A.F. (V.R.) —a second son.

Marriages

COXON—BOWERS.—On December 1st, 1944, in India, Victor Coxon, M.D., Major, R.A.M.C., to Mary Bowers, M.B., Captain, R.A.M.C.

DONALD—HALL.—On February 9th, 1945, at Paignton, J. H. Donald, L.D.S., of Falmouth, to Elizabeth Hall, of Torquay

WATTS—LYNCH.—On February 12th, 1945, at Northampton, John Aubrey Ewart Watts, M.B., B.S., to Mary Elizabeth Maureen Lynch S.R.N.

Deaths

BLENKARN.—On February 14th, 1945, suddenly, the result of a road accident at Redhill, Edith Mary Blenkarn, aged sixty-two (Guy's 1907–19 2).

BRODRICK.—On March 9th, 1945, at Clover, Widemouth Bay, near Bude, Charles Cumberland, M.R.C.S., L.R.C.P. (late of Tavistock), in his eighty-ninth year.

CHAPPLE.—On March 8th, 1945, at 42, Orchard Court, W.1, Harold Chapple, M.Ch., F.R.C.S., F.R.C.O.G., dearly loved husband of Irene. No mourning.

CLARKE.—On February 21st, 1945, of 10, University Road, Leicester, Astley Vavasour Clarke, J.P., B.A., M.D.

HOWELL.—On March 4th, 1945, at 7, Imperial Square, Cheltenham, John Howell, C.B.E., F.R.C.S., aged seventy-three.

MALT.—On March 5th, 1945, Douglas Frank Malt, Captain, A.D. Corps.

PHILLIPS.—On February 7th, 1945, Richard Edward Game Phillips, of Montgomery, late Major S. African Constabulary and Captain, R.A.M.C.

RICHMOND.—On February 26th, 1945, at Bryn Hafed, Trefriw, Benjamin Arthur Richmond, M.D., late Demonstrator in Chemistry and Physics and Chemical Pathology (Guy's).

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1479 *31st March, 1945* *Ninepence*

PASSIM

SPRING has come to the Hospital and with it an increase in the activities of that busy hive of industry, the Works Department. For weeks now the Colonnade has been echoing to the hammers of the workmen in the Surgical Block and at last our curiosity as to the outcome of their efforts has been rewarded. Martha Ward is no more, but from her aged bones a new and beautiful tribute to the Hospital's administration has arisen—the new Counting House.

Bearing in mind the ever lengthening waiting lists of patients and the ever present threat that Guy's teaching may, at the end of the E.M.S. era, be dislocated through lack of clinical material; some might wonder that such care should be lavished upon this new administrative building rather than upon the redecoration and re equipment of some of the old wards for patients instead of for clerical staff. In fact, two such wards there are: Lydia and Queen, but both wait upon the availability of domestic staff, before they can re-open. The apparent relative increase in administrative accommodation is a secondary rather than a primary ailment. If the forms, accounts and memoranda received from ministries and Government offices increase in volume then must the machinery that has to receive them, expand proportionately. When the wartime farmer converts his living room into an office and calls in his wife from tending the chickens, that he may dictate a letter to her; one does not blame him—one sympathizes rather. Let us then keep vigil on these central sources of control and demand their reduction to proportions more seemly, when the war is won.

Another interesting development that the Spring has evolved is the problem of the chains around the Park. At present the Park itself is traversed by various bald pathways, leaving small, rather dispirited-looking grass plots for the enjoyment of the crowds that throng there in the lunch interval. To counteract this growing alopecia, the chains protecting the grass have been tightened up and painted white; this move is considered rather unsporting by the majority who now have to jump over the chains to violate the grass—no doubt, however, some philanthropist will break them down again shortly and so restore the *status quo*.

THE subject of women students in Medicine has raised many issues in our pages recently, and it has been encouraging to see the interest that has been taken in the matter. Last week a new development occurred; we were rudely awakened from our postprandial snooze in the Park by four stalwart young maidens, who presented a paper, declaring that we wanted women students at Guy's, for our signatures. We pointed out that we didn't, but this in no wise deterred them and we only escaped unscathed by pleading a medical round that we had to attend. Whether or not one approves of these privateering methods, it shows us just how much in earnest these young ladies are and to what ends they will go to achieve their purpose.

WE must congratulate Dr. Clifford Hawkins on his appointment—Medical Superintendent, Preston Hall; also on his appointment as pre-clinical tutor at Guy's. In his place, as Medical Superintendent of The Wildernesse, we welcome Dr. Philip Evans, G.M., who has been invalided out of the Navy.

SOME time ago it was the custom at Guy's for the House Officers to post in the Colonnade a list of patients who might be of interest to men reading for their Final examinations. At a time like this, when good teaching cases are so rare, such a scheme might prove invaluable. Could it not be re-established?

The Prevention of Cancer

By W. SAMPSON HANDLEY,

Consulting Surgeon to the Middlesex Hospital, Demonstrator of Anatomy, Guy's Hospital, 1899–1901.

A Paper read before the Cambridge Medical Society, November 1st, 1944.

THE prevention of cancer is a subject which has hitherto stirred but a languid and unpractical interest in the minds alike of doctors and laymen. To the pessimist attempts to prevent the disease appear a waste of time, for he believes that its cause is unknown and its cure impossible. Yet I think I can show you that by the adoption of certain simple preventive measures one rare form of cancer could be abolished, and a common variety of the disease reduced to about one-eighth of its present frequency. The preventive value of radiation applied to precancerous conditions has not been fully recognised. It can be shown, too, that a great deal is known about the causation of the disease, as I have tried to prove in my book, "The Genesis of Cancer."[1]

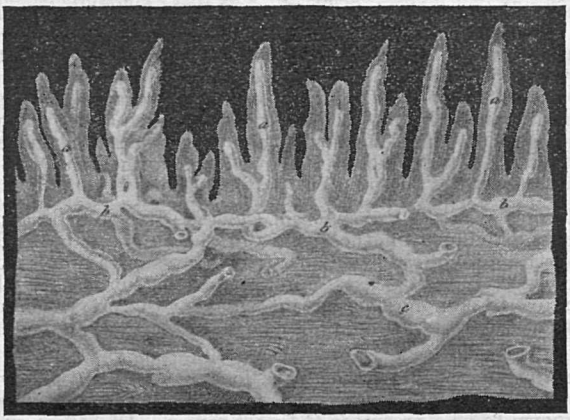
The current doctrine as to the causation of cancer is that it is due to chronic irritation, a phrase which is little more than a cloak for ignorance, for some skin irritants have no power to induce the disease. It is now generally agreed that the disease is in origin local, and recognised laws govern its spread to distant parts of the body—by lymphatic embolism along main trunks to the glands, by the continuous growth of cancer-cells along the fine lymphatics, (a process to which I have given the name of "permeation"), and, to a certain extent, by infiltration of cancer cells through the tissue interspaces. Rarely, and usually in a late stage, it may spread by the blood-stream. It is known that epithelial surfaces which have been attacked by syphilis or tubercle are liable many years later, when perhaps only a sound scar remains, to become the seat of cancer. Prolonged application of tar or soot may produce it, so may exposure to sunlight or ultraviolet rays, or X-rays or the rays of radium. Some forms of it are certainly due to a virus. Injection or local application of œstrin in large doses may cause breast-cancer, and the use of œstrin for menopausal conditions is certainly dangerous in patients with precancerous conditions of the breast—*e.g.*, cystic mastitis. Bittner has lately shown that mice of a strain relatively immune to breast-cancer are apt to develop the disease when suckled from mice of a strain prone to cancer. Whether this is due to some chemical substance in the milk or to a living virus has not yet been determined.

Thus these cancerogenic agents are a very miscellaneous collection, but it was shown by Victor Bonney that always in precancerous areas there is increased cellularity of the sub-epithelial tissues. I have been able to prove for some forms of cancer that this increased cellularity is due to a chronic lymphangitis which obstructs the lymphatics of the affected area, and I believe that a basic and perhaps universal condition for the origin of cancer is a prolonged stoppage of the circulation of tissue fluid through the area of lymphatic block.

Obstruction of the drains of a field will entirely alter the character of its vegetation within a few years and lead to the replacement of nutritious grass by rushes and bog weeds. Drinker and Field have shown that in areas of lymphatic œdema the tissue fluid is unduly concentrated and rich in proteid. The free access of the hormones by which the body maintains local control of the tissues is interfered with. Can it be wondered at that the basic changes in the environment of the cells—this over-nutrition and removal of control—may lead to that assertion of complete local cell-autonomy which is the peculiarity of cancer?

Bacteria and viruses, chemical irritants such as tar, physical irritants such as X-rays and ultra-violet light do play an important part in cancer-causation. They act by causing preliminary lymphangitis of the capillary lymphatics, one of the commonest but the least recognised of pathological processes. It is a strange fact that the word "lymphangitis" is not to be found in the index of the two best and most popular works on surgical anatomy. Works on anatomy ignore the simple fact that a blind lymphatic end-sac is the central structure of a skin-papilla, though the lymphatic capillaries of the skin were correctly described by L. Teichmann[2] about the middle of the nineteenth century (See illustration). He employed direct injection and I, independently, arrived at the same conclusions by studying sections of lupus and of skin-lymphatics permeated by melanotic sarcoma.

When you come to think of what happens in an area of acute inflammation—how tissue fluid is poured out from the blood-vessels and how all the cells in the district actively proliferate as long as the inflammatory œdema persists, you will see that lymphœdema is Nature's chosen method for inducing cell proliferation. If lymphœdema becomes chronic as in elephantiasis the induced cell proliferation may assume enormous proportions, and in this disease after many years cancer may be the final outcome. But the lymphatic block, instead of affecting a whole limb as in elephantiasis, may be confined to a small and even microscopic area of tissue, such as an infected hair follicle, or a milk duct which is invaded by surface skin organisms. The inflammation soon subsides, and may even pass unnoticed by the patient, but if it leaves behind it obstructed lymphatics the conditions are established for the appearance of a cancer twelve to fifty years later. The minimum incubation period of cancer in the human race may perhaps be inferred from the fact that the first X-ray cancer occurred twelve years after the discovery of X-rays. In lupus cancer the incubation period may be as long as fifty years.



The devastating consequences of lymphatic obstruction when on a large scale it affects a whole limb, as in tropical elephantiasis, have long been recognised. But pathologists have remained blind even to the recognition of the same process of obliterative lymphangitis when it occurs on a small or microscopic scale in the minute lymphatics of origin such as those found in the papillæ of the skin or in the submucosa of the tongue. The very existence of these capillary lymphatic vessels is to many pathologists a mere anatomical rumour.

One of the principal obstacles to general acceptance of my lymph stasis theory of cancer is its simplicity. The ætiology of cancer has always been regarded as a profound mystery about which little can be said. But may I remind you of the words of Newton: "Nature is pleased with simplicity and affects not the pomp of superfluous causes." The late Lord Rutherford expressed a similar idea when he said of atomic physics: "It has been of great interest to note the comparative simplicity of the ideas that have ultimately emerged. . . . It is an illustration of the fact that Nature appears to work in a simple way, and that the more fundamental the problem, often the simpler are the conceptions needed for its explanation" ("Rutherford of Nelson," by Ivor Evans. Pelican Books).

The great lesson John Hunter taught, not so much by his writings, which are often difficult and obscure, as by the creation of his great museum, is that in dealing with any subject in medicine you must begin by studying the relevant anatomy and physiology before you proceed to consider the pathology. Only by this route can you lay the foundations for rational preventive and curative treatment. I am trying to apply this rule to the consideration of my subject to-night and must refer in more detail to certain neglected points in the normal and morbid physiology of the skin-papilla. Note that normal skin lymphatics are rarely visible in sections, a fact which perhaps accounts for the neglect of lymphatic anatomy by dermatologists.

It is a fact of capital importance in the ætiology of carcinoma that when it arises on a surface covered by squamous or columnar or transitional epithelium it is always preceded by papillomatous hypertrophy, and when it begins on a mucous membrane lined by a glandular epithelium—*e.g.* the stomach or the intestine—it is probably always preceded by the formation of adenomata, innocent tumours, sessile or stalked, covered by columnar epithelium and containing glandular elements. One of these may sooner or later become malignant. If we can find out how papilloma and adenoma originate we shall be well on the track of discovering the origin of cancer.

The Origin of Papilloma.—If you turn to works of dermatology you will find that the description given in them of papilloma is a purely anatomical or morphological one, containing no reference to physiological working. The papilloma is regarded as an acanthoma or simple tumour produced by the proliferation of the prickle-epithelium (Unna), and the conditions found in the dermis are simply ignored. But nearly always when it is looked for evidence of dermal lymphangitis and blocking of the dermal lymphatics can be demonstrated.

As I have said in my book: "The papilla is a little physiological engine. From its blood capillaries there exudes into its connective tissue a constant nutritive stream of dilute blood plasma at a certain pressure. The excess of fluid is removed and the equilibrium maintained by the drainage action of the central lymphatic. Block this lymphatic and what will happen? The first effect will be a rise in the pressure in the intercellular spaces of the papilla, and on ordinary hydraulic principles the papilla will increase in size until the intercellular pressure is equal to the pressure in the capillary blood-vessels. A late effect will be the over-nutrition and consequent proliferation of the papilla itself and of the overlying epithelium." If this process is continued through the years the innocent papilloma may become a carcinoma.

Radiation Treatment in the Prevention of Cancer.—It would be admitted by most radiologists that a papilloma on the surface of the skin can be made to disappear under an appropriate dose of radiation either by X-rays or radium. At any rate, this is true in a large percentage of cases, and a strong presumption is thus raised that radiation may prove to be a most important agent for the prevention of cancer. The mode of its action is uncertain, but probably it directly inhibits proliferation of the epithelium of the papilloma.

Chronic Mastitis.—In the *Practitioner* as long ago as 1910 I advocated a short course of X-radiation for the treatment of chronic mastitis, which especially in its cystic form is known to be a precursor of breast-cancer. Of course, unduly prolonged treatment by X-rays may be dangerous and may be itself a cause of cancer.

Chronic mastitis is initially a chronic lymphœdema of one or more of the lobes of the breast. You will remember that the breast is composed of about fifteen separate sector-shaped glands arranged like the segments in a box of shortbread. The duct of each lobe opens separately upon the surface of the nipple, which accordingly presents about fifteen distinct orifices, any one of which is liable to an ascending infection, nearly always staphylococcal, from the bacteria present on the skin surface. The infection readily spreads to the plexus of lymphatics surrounding each duct. Lymphatic thrombosis follows and the lymphatic vessels are soon replaced by little solid cords of fibrous tissue At the next menstrual period, when in the normal course of events vascular congestion floods the breast with tissue fluid, the lobe or lobes whose lymphatics are blocked is unable to empty itself at the end of menstruation. It remains in a condition of lymphatic congestion aggravated at each succeeding period. The affected area can now be felt as a vague granular sector-shaped induration. In course of time the endothelium lining the distended lobular lymphatics proliferates and blocks their lumen. The usual effects of chronic lymph obstruction follow—namely, a violent stimulus to the proliferation of the connective tissue and the appearance of papillomatosis in the small ducts. The condition has now become a precancerous one. The rise in the fluid pressure in the tissue spaces of the breast, and obstruction of the lumen of the small ducts may lead to cystic distension of the ducts, and the mastitis assumes the cystic form.

In the early stages of chronic mastitis three half-erythema doses of deep X-rays will frequently bring about the complete disappearance of the sector-shaped indurations. It is fair to assume, therefore, that it imposes a check on the proliferation of the precancerous epithelium and safeguards the patient against cancer at any rate for some years. I have had some hundreds of cases treated in this way, for many of which I should have otherwise felt compelled to advise mastectomy. Some of them

I have watched through long periods of years, and those who have subsequently developed carcinoma could be counted on the fingers of one hand. But for cystic mastitis mastectomy is best.

The Operative Prevention of Cancer.—Moles.—If we include sarcoma among the cancers a typical instance of the operative prevention of cancer is the removal by clean and complete excision of a melanotic mole which has given warning of a change in its nature by an increase in size and prominence or by bleeding. If a mole is in a situation liable to irritation it is better to remove it even if it appears quiescent. I would strongly warn you against applying caustic to a mole under any circumstances, for that is the quickest way to convert it into a melanotic sarcoma. Cut it out cleanly or leave it alone.

Precancer of the Breast.—In about three cases of bleeding nipple where I could feel a tiny lump near the nipple, pressure upon which produced the bleeding, I have been able to cut down upon the lump and remove it with a portion of the duct in which it was lying.[1] In these cases the diagnosis was duct papilloma, but a section showed that the fibrous core of the papilloma was infiltrated by epithelial cells—that it was, in fact, an incipient carcinoma—call it a precancer—which had not yet succeeded in infiltrating any tissue except that of its own substance. These cases show what is, perhaps, the usual mode of origin of breast carcinoma.

The Way of Life to Avoid Cancer.—If my lymph stasis theory of the origin of cancer be correct it would appear essential to maintain the lymphatic circulation of the body in full activity. The late Professor E. H. Starling showed that a resting limb produces hardly any lymph, but as soon as the muscles are thrown into action a copious flow occurs. Cancer appears to be less common in wild animals which are compelled to lead an active life than in domesticated animals. It appears to be rarer in uncivilised communities than in cities. The glands which have a twenty-four hour working day, like the lachrymal and the salivary glands, are less liable to cancer than organs which have long idle periods such as the breast and uterus. The monthly flushing of these two organs with fresh tissue fluid at the period is probably a safeguard against the danger, and after the menopause the incidence of cancer in them increases.

Muscular exercise brings into play all the mechanisms upon which, in the absence of a lymphatic heart, the maintenance of the lymphatic circulation depends—the aspiration action of deep breathing, the pressure of pulsating arteries upon their comitant lymphatics, and of contracting muscles upon the muscular lymphatics.

Gland-activity, like muscular activity, stimulates the formation of lymph, but does nothing to accelerate its movement. Thus insufficient exercise associated with over-nutrition and excessive glandular activity may combine to produce a general lymph stasis which must aggravate the effects of any existing local lymph stasis.

The Avoidance of Infections.—It is, however, certain that the avoidance or efficient treatment of the infections liable to produce local areas of lymph stasis is the most important means at our disposal for preventing cancer. In this connection dental infection and the secondary infections of the mouth, stomach and bowel arising from it, play a part the importance of which is even now not fully appreciated. I have only once seen cancer in a mouth which a dental surgeon would consider clean.

To Help the Thyroid.—As old age approaches it may be inferred from the greying of the hair, the slowing of mental activity, the increased sensitiveness to cold and the puffy lower eyelids, that the thyroid is undergoing atrophy, and that the lymphatic circulation—so obviously defective in myxœdema—is in consequence sluggish. I believe that most old people would be the better for a small weekly dose of thyroid—say, two grains. The infrequency of cancer in persons who, when young, have suffered from hyperthyroidism suggests that by stimulating the lymphatic circulation a weekly thyroid tablet may help to prevent cancer.

PREVENTION OF SEX CANCER.

I come now to the difficult question of sex-cancer and propose to treat it frankly.

Penile Cancer.—Penile cancer is usually found in association with congenital phimosis, and there is no reported instance of the disease in a circumcised Jew. Wolbarst, after a search of the literature, found one Jewish case; the patient was uncircumcised. S. K. Ngai[3] collected 107 cases of cancer of the penis occurring in Chinese and, among 88 of these cases who made a positive statement on the subject, 87 had had phimosis.

Beneath the phimotic prepuce shed epithelium and retained secretions form an admirable breeding-ground for a mixed collection of bacteria. Sooner or later a chronic infective balanitis is set up, followed by lymphangitis and obliteration of the cutaneous lymphatics of the glans. Papillomata appear on the glans and one of them ultimately may become a carcinoma. It is significant that, according to Ngai, the disease is common in China among farmers and coolies, rare in the educated classes with their higher standard of personal cleanliness.

It may be objected, admitting the frequent existence of collections of mixed bacteria under the prepuce, that evidence of their infective potency is lacking. But it has been proved by the experience of this war that young men living under conditions of active service which make personal cleanliness difficult are prone to a non-specific, non-gonococcal urethritis, of which sub-preputial sepsis is certainly the cause.

Wing-Commander C. L. M. McElligott[4], speaking in a recent discussion at the Royal Society of Medicine on Non-specific Epididymitis, said :—

"Primary non-gonococcal urethritis is a common condition, and between 30 and 40 per cent. of all cases of urethritis treated at Service venereal disease centres are of this type. The condition is usually not severe, sometimes escapes the patients' observation, and, except where it is due to coliform organisms, is not affected by sulphonamide chemotherapy.

"Since the sulphonamide era, gonococcal epididymitis is uncommon, and the few cases of epididymitis I now see more often than not follow a non-gonococcal infection of the urethra. I feel that these infections are usually venereal and that they may be acquired from a consort, whose previous gonococcal cervicitis has been successfully treated with sulphonamides, but in whom the almost invariable secondary infection has not been cured."

It is not clear why previous gonorrhœa need be assumed to have occurred in such cases. Mixed non-specific infections of the vagina are probably common enough, and may be transmitted in coitus. But it need not be assumed that in all cases sexual intercourse preceded the attack of urethritis. The conditions of active service make bathing and general hygiene difficult, and facilitate the spread up the urethra of the sub-preputial mixed bacterial flora. In any case Wing-Commander McElligott's experience demonstrates beyond doubt the frequency and the infective potency of preputial sepsis, quite apart from the gonococcus and the treponema.

It is an interesting fact that the earliest known Egyptian mummy, that of Ra-Nefer, recently destroyed in the bombing of the museum of the Royal College of Surgeons, had apparently been subjected during life to the operation of circumcision. Thus it is probable that the Mosaic Law, in adopting this hygienic measure, utilised a still earlier racial experience, and that the operation is of Arabian origin. The weighty evidence of two civilisations in its favour need not lead our own to adopt it, for, as I have shown, its advantages can be attained without any removal of tissue by the simpler method of slitting up the prepuce in the midline. Mere stretching of the preputial orifice is unsatisfactory, for it is often followed by recontraction. Circumcision may be preferable to dorsal incision if the prepuce is a long one.

On the other side of the world, and separated by the great ocean spaces from Egyptian influence we find circumcision at puberty practised in Fiji as a ritual observance. It was probably established for hygienic reasons by some far-sighted reformer. It is evident that the link between religion and hygiene, enshrined by our forefathers in the phrase "Cleanliness is next to godliness," is an absolutely primeval one.

Cancer of the Cervix Uteri.—Evidence from all over the world, which I have elsewhere summarised, establishes beyond doubt the fact that carcinoma of the cervix in Jewish women is about eight times less frequent than in non-Jewish women living in the same communities. The evidence, to which attention was first pointedly drawn by Maurice Sorsby in 1931,[5] comes from Amsterdam, New York, the Mayo Clinic, Paris, Buda-Pesth, Munich and Montreal. In New York, where the largest statistics are available, cervix cancer is eight to fifteen times less frequent in Jews than in non-Jewish women.

Sorsby attributes this to the hygienic ritual imposed on Jewish women by the Mosaic Law, and others have postulated a racial immunity to cancer, an explanation contradicted by the frequency among Jews of certain other forms of cancer—*e.g.*, of the breast and rectum. But surely the freedom of the Jewish woman from carcinoma of the cervix must be correlated with the total freedom of the Jewish male from carcinoma of the penis. The hygienic operation of circumcision protects both sexes from an interchange of the mixed sub-preputial or vaginal bacterial flora. I have shown that it has the same effect among the inhabitants of Fiji—a proof that race has nothing to do with the matter. I append a quotation from my lecture in 1936[6] :—

"During a brief visit to Fiji in 1927 my attention was drawn to the occurrence of carcinoma of the penis in the Indian inhabitants originally imported from India, and to its absence among the aboriginal Fijians. The two races live side by side without mixing and the islands contain about 90,000 Fijians and 70,000 Indians. The Fijians, but not the Indians, practise circumcision at puberty. I endeavoured to find out the relative liability of the two races to cervix cancer.

"A search through the careful reports of the Colonial War Memorial Hospital at Suva, Fiji, shows that during the eight years 1925–32, inclusive, three cases of cervical carcinoma in Fijians were admitted, and twenty-six cases in Indian women. Thus the smaller of the two population groups, the one not practising circumcision, shows an incidence of cervix cancer upon its women more than eight times greater than the incidence of the disease upon the other circumcised nation. The freedom of the Fijian race from cervix cancer must be attributed to the protection which the hygienic operation of circumcision affords against mixed bacterial infections of the cervix during coition. It is customary to ascribe cervix cancer to trauma of the cervix during parturition, but, if this were the case, both races should be affected equally."

Public Education.—The question of the prevention of cervix cancer is so important that I have not hesitated to use complete frankness about it in a leaflet[7] issued for public information at Bournemouth, where for two years I have been directing the first municipal cancer clinic to be established under the Cancer Act of 1939. Should the community—the final arbiter—decide that a taboo on such matters must still be maintained, the price of that decision will be exacted. The happiness of four thousand families in England and Wales will annually be sacrificed in the future as in the past to uterine cancer.

REFERENCES.

1. W. Sampson Handley. "The Genesis of Cancer." London: H. K. Lewis, 1931.
2. Ludwig Teichmann. "Das Saugadersystem." Leipzig, 1861.
3. S. K. Ngai. *American Journal of Cancer*, 1933, xix, 259.
4. Wing-Commander G. L. M. McElligott, Contribution to discussion on "Non-specific Epididymitis." *Proc. Roy. Soc. Med.*, vol. xxxvi, p. 326.
5. Maurice Sorsby. "Cancer and Race." London, 1931.
6. Handley. Mitchell Banks Memorial Lecture on "The Prevention of Cancer." *Lancet*, 1936, i, 987.
7. The author will be pleased to send a copy to any reader interested. Address postcard to 29, Welbeck Street, W.1.

Obituary

HAROLD CHAPPLE, M.Ch., F.R.C.S., F.R.C.O.G.

HAROLD CHAPPLE, Senior Obstetric Surgeon 1925–45, died suddenly on March 8th, 1945, at the age of sixty-four years. He entered Guy's, from Cambridge, in the spacious days of Edward VII. He was an outstanding and most deservedly popular member of a band of men characterised by culture and by good sportsmanship in every sense of the term.

In due course he became house-surgeon to Arbuthnot Lane, to whose firm the writer had the privilege of being appointed ward-clerk at that time. His great charm was at once evident; although we ward-clerks were small fry, whilst Harold was the head man of the tribe, he treated us as intellectual equals. He took endless trouble to introduce us to the art of clinical medicine and surgery; above all, he taught us how to handle patients with sympathy and understanding. He trusted us, and we respected him accordingly. Out of hours there was no question of rank; we were happy and, I trust, efficient.

Charm, as is well recognised, may be merely superficial; but Harold Chapple's charm was based on genuine sympathy. He developed that divine gift to a degree that filled me with admiration in those days and after, when I had the honour of becoming his colleague. The practice of gynæcology is apt to breed impatience and a measure of intolerance, but he actually felt for those suffering women whom he had

elected to attend in their hours of need. At one time he was considerably criticised for his insistence upon the merits of Cæsarean section as opposed to "conscientious" mutilation. Therein he was a pioneer; it is doubtful whether he has ever been fully accorded that credit in the progress of obstetrics which is certainly his due.

Another of Chapple's great qualities was that of courage. We have all, during the last five years, encountered examples of courage that have almost exceeded human belief. But when he himself was afflicted, not long before the War, and when the shadow of death lay over him, he did not flinch; he carried on with his usual good cheer and with courage that has been truly phenomenal.

Possibly the one great gift that has enabled our nation to endure is that of humour. In this direction Harold reigned supreme: a trifle ironical, sometimes caustic, always tolerant and kindly. Would he were here to comment on these ill-penned lines! Perhaps I may be forgiven for recording a casual remark of his which always appealed to me. One afternoon at Guy's he was performing an extremely difficult and laborious operation. It was one of those days when everything seems to go wrong and to present the greatest difficulties. As the operation was finally being brought to a successful conclusion, an ingenuous and newly-appointed dresser who was standing by, asked: "Will this operation do the patient any good?" Anyone else would have consigned the unfortunate man to Hades. Chapple merely quietly replied: "That's roughly the idea."

His manners were perfect. May that great spirit which underlay and prompted his good manners remain with us always! F. C.

An Appreciation

I HAVE been asked to write an appreciation of my dear friend, Harold Chapple. I would epitomise his character in three words—Charm, Courtesy and Consideration. To few man has it fallen to be so beloved, not only by their patients, but by all with whom they have worked—sisters, nurses, students and doctors.

Harold loved life, loved his work and all humanity. He often said to me: "How lucky you are to have all types of patients—whereas I only deal with women." Loving his chosen branch of our profession as he did, yet he was essentially a man's man—a tennis "blue," a good golfer and good companion. In his work he was of the very best, a first-class accoucher with, as he expressed it, a niblick in his bag to get out of the bunkers with which maternity abounds; as a surgeon, a first-class operator. His plastic perinæorrhaphies were truly brilliant and brought years of good health to very many women who had endured previous years of constant suffering.

In over thirty years of helping him operate I have never known him lose either his temper or his nerve in the theatre, no matter what crisis may have arisen. No wonder the theatre sisters and nurses loved to work for him. As a teacher he was exceptional, he loved the young and they in return venerated him. One of his most valued possessions was a signed photograph of himself and a class of students with the proud caption of "Pass List 100 per cent."

But my happiest memories are away from work—on the golf-course and around the table; a wonderful host and a wonderful pal; witty, charming and entertaining. He died, as he would have wished, in harness, helping others to the very end and with his passing leaves a gap that it is impossible to fill; loved and missed by his friends and patients both in the Borough and in the more stately homes of the West End.

D. MacM.

Correspondence

POST-MORTEM INSTRUCTION.

To the Editor of the GAZETTE.

SIR,—While we realise that every effort is being made on the part of the Medical School authorities to provide the best possible facilities for teaching at post-mortems, we feel that the adoption of some of the following suggestions would materially improve the situation which at present jeopardises the teaching of practical pathology:—

(1) In view of the large numbers of students who attend post-mortems, the provision of some sort of arena or better raised seating accommodation is necessary. Until better accommodation can be provided it seems necessary to exclude from post-mortem examinations any students in the pre-clinical stages of their course who would otherwise be able to attend, in order to reduce congestion.

(2) A closer relationship between the clinical studies and post-mortem examinations would greatly enhance their value. This could be achieved by making sure that an adequate clinical history is presented with each case by the clerk. While it is appreciated that the demands of the present-day conditions make their time very precious, occasional reversions to the old custom whereby assistant physicians and medical registrars taught on post-mortem cases, would be valuable in preventing the tendency to divorce clinical medicine and surgery from pathological appearances.

While one is always uncertain to what quarter suggestions of this character may best be made in hopes of receiving a sympathetic hearing, we hope that in your pages it may be realised that these are not the grumblings of a querulous minority, but practical suggestions which, if implemented, would greatly benefit all.

Yours, etc.,

P. E. BROWN, RICHARD NEVE,
H. G. DIXON, R. OWEN,
W. E. D. EVANS, B. SYMONDS.

Medical School, Guy's Hospital, S.E.1.

IMPRESSIONS FROM A MUNICIPAL HOSPITAL

To the Editor of the GAZETTE.

SIR,—Owing to the present size of the obstetrical firms at Farnborough Hospital it has recently become necessary for a certain number of students to do their "take-in" at a municipal hospital in Sussex, the scheme being that two students become resident for a period of three weeks.

Soon after arrival at this hospital we found that we were not expected to limit our sphere of activity to the midwifery wards, but were, indeed, encouraged to participate in all branches of medicine that were carried out at this place. Thus our first and probably greatest lesson was to think of surgery, medicine, obstetrics, gynæcology and pædiatrics throughout the day, and not to allow one's mind to steer a straight course through the necessary pseudo-specialisation of one's clinical appointments.

As there are no house-men at this hospital, we were given the opportunity of gaining much practical experience that would not otherwise have fallen to our lot. For instance, the setting up of blood transfusions became our monopoly; at the same time the pit-falls of this apparently simple manœuvre soon became obvious. The difficulty of entering the vein was not pronounced, but I seemed to have an unfortunate tendency to overshoot the vein and puncture the posterior wall, thus gaining a hæmotoma as soon as the drip was started. The cause of our other difficulty is as yet unknown. The needle is apparently in the vein, but no amount of twisting and turning will make the blood flow back along the tubing. Then, when the needle is withdrawn, a flow of blood ensues that could only come from a punctured vein. The needle, when tested, is found to be patent. The only solution seemed to be that it was the work of gremlins, more especially as this difficulty only arose twice and then both times in the male medical wards!

Our opportunity for practising venepuncture, apart from transfusions, was considerable. In the ante-natal clinic we did between forty and fifty W. R.'s each week. In the wards there were intravenous medicaments to be given, in the labour wards, intravenous ergometrine, and in the theatre, pentothal. The conclusion was that "getting into a vein" was an essential performance and should be done as naturally and as easily as taking a blood-pressure. In short, to quote the surgeon there, one should be able to carry out venepuncture "night or day, drunk or sober."

In the surgical wards we saw many cases that had we not been living in we would have missed. The difficulty of diagnosing the "acute abdomen" was thrust upon us early. Out of ten cases admitted as acute abdomens only two remained so after examination. One was a perforated appendix, the other a strangulated internal hernia. Amongst numerous interesting cases we saw one case of an intussusception in a woman aged sixty-eight years. The history, of four weeks' standing, was of lower abdominal pain with occasional "twitches" of a more severe colic. On examination there was tenderness in the R.I.F. The patient was X-rayed (? carcinoma of ascending colon) and the barium follow-through showed a text-book picture of an intussusception. At operation the ileum and cæcum were found inside the ascending colon and a single polypoid adenoma of the ileum was shown to be the cause.

I had the good chance to be the first on the scene when three cases of acute appendicitis were admitted. None of the three proved to be a case of acute appendicitis. The first was in a girl, *æt.* thirteen years, who had just started menstruating, and her right iliac pain was clearly associated with that. The second was in a boy aged twelve years, who, when in hospital, complained of nothing and no abnormality was found on examination. The third was in a woman, aged twenty-three years, who was two months pregnant. I confidently diagnosed an ectopic, but later the case was undeniably proved to be an acute salpingitis; or do sulphonamides cure ectopics?

On the more practical side we assisted at operations, and were able to see different instruments and methods in use. For an end-to-end anastomosis the surgeon uses a Furniss clamp; with this weapon the operation appeared incredibly simple. Stitching and minor operations were our pigeon. The technique of wielding needles in confined spaces and controlling the point was certainly more apparent when I left than when I arrived. Alas, Michels' clips are still rather elusive.

On the medical side there were also many interesting cases. There was a Von Recklinghausen's disease with multiple neurofibromata and spastic paraplegia, due presumably to a nodule on a root inside the spinal canal. We saw a case of polycythemia vera with the classical bluish-red skin in a plethoric man who complained of headache, lassitude and breathlessness. Another case that caused much discussion was that of a man, aged twenty-nine years, who came in as an acute appendicitis. On examination he did not give the true-bill picture and was retained in hospital for observation. By the next day some glands in the neck had enlarged and he was transferred to the medical wards. Here, on examination, the glands in the neck and axillæ were found to be palpable and petechial hæmorrhages were seen in the mouth. A blood count was sent off and the result was 'phoned back—20,000 white cells—a rather border-line figure for a diagnosis. It was decided that probably it was a lymphatic leukæmia. Later, however, the gloomy prognosis was confidently changed; the patient had a positive Paul-Bunnell reaction.

In the midwifery wards the high standard of cases was maintained. In the antenatal clinics we saw nearly every position that a fœtus could possibly adopt. During the routine examination of all new patients we were able to hear many chest physical signs. One patient was a case of dextro-cardia with complete rotation of the abdominal organs, including an appendicectomy scar on the left-hand side. In the wards we had a placenta prævia with profuse hæmorrhage, a case of eclamptic fits and a case of acute hydramnios.

The children provided our three-star experiences. We soon ran up against the difficulty of the acutely dehydrated baby with diarrhœa and vomiting. The first case was given an intravenous dextrose-saline drip; this proved unsuccessful, as the wriggling of the baby continually stopped the drip. Our attention was drawn to a letter in a past copy of the *British Medical Journal* suggesting an intranasal gastric drip to combat acute dehydration in babies. This method was adopted in the next case. A 20 per cent. glucose solution was dripped in at fourteen drops per minute. The dehydration was most certainly cured, but, unfortunately, the baby died of pneumonia. The next dehydrated baby was also given a gastric drip, this time at five drops per minute. This proved very satisfactory and was used successfully in another case. In neither case did the vomiting continue after the drip was set up.

For a museum of clinical signs there assuredly is nowhere more rich in exhibits than the chronic wards of a municipal hospital:—

> "Here, where men sit and hear each other groan;
> Where palsy shakes a few sad, last grey hairs. . . ."

The sight of old men and women, some of whom were famous in younger days, lying

now, forgotten and unwanted, in cots, past the helping hand of medicine, dead yet living, is a deeply pathetic sight; and certainly converts one to support the disciples of euthanasia.

Thus to conclude; after my stay here I found that my clinical experience had increased by leaps and bounds. No longer were patients too ill to be seen by a student; no longer were there so many round the bedside that the patient was exhausted by continual examination. I became more than satisfied that Mr. T. B. Layton was right when he exploded the notion that "all work done in these (municipal hospitals) is doomed to be second rate." And now I feel that it would be of everlasting benefit if a short spell of our clinical appointments could be spent at a municipal hospital, this time being incorporated naturally into the post-war curriculum of medical education.

Yours etc.,

M. D. WARREN.

IMPRESSIVE TEACHING IN HOSPITAL.

To the Editor of the GAZETTE.

SIR,—There must be many old Guy's men who can recall instances of impressive teaching during the time they were at Hospital. Three examples occur to my mind. When dressing for Sir Henry (then Mr.) Howse, he had just released a strangulated femoral hernia, and told us that he once cut his forefinger on the edge of Gimbernat's ligament when operating for a similar condition.

On the occasion of his last clinical lecture, Mr. Arthur Durham chose "Cancer of the tongue" as his subject, and collected a number of his old patients whose tongues he had removed wholly or partially during the previous twenty years. Towards the end of a most interesting talk he said with impressive emphasis: "Gentlemen, if you have an enemy stamp him out ruthlessly if you can; soothe him if you can't; but never, never irritate him."

Another time the then surgical registrar, whose language was at times rather striking, was going round the new admissions, one of whom had a compound fracture of the tibia which had involved the anterior artery, and he asked for a description of the operation for tying it in its middle third. Having duly found the text-book landmark, one was about to place an imaginary ligature round the vessel, when he said: "There's something you have forgotten to do. This is where you go down on your knees and thank God you've found the d——d thing!"

I don't suppose that any of us who were present on these occasions have forgotten these incidents.

Yours, etc.,

Lisle Court Farm, Lymington. C. A. ENSOR.

Sport

Boxing

UNITED HOSPITALS *v.* OXFORD UNIVERSITY.

(*At Oxford Town Hall, Thursday, 22nd February*, 1945.)

The strength of United Hospitals boxing was demonstrated by victory of six events to three over Oxford University. At the moment the hospitals are particularly strong in the light-weight, welter and middle-weight, and five of their wins were recorded in these weights.

Of the Guy's contingent, only two of the six selected had opponents, and both well won their bouts.

In the welter-weight S. F. A. Westgate (Guy's) met A. M. Shaw (Magdalen), and the strong, fearless determined rushes of the latter were met with solid punches to the head and body, with Westgate following up continuously in a non-stop slam, landing with some excellent short rights which compelled the referee to stop the contest in the third round. This was undoubtedly one of the best bouts of the evening.

In the middle-weight match C. H. Kinder (Guy's) did most of the leading against A. C. Johnstone (B.N.C.) although he was unduly cautious at the start. His left was more in evidence than usual, but his right hand carried a damaging punch, which was timed perfectly, whenever his plucky opponent was forced on the defensive, and in the exchange of blows was never in danger and won with something to spare.

RESULTS.

Fly-weight.—B. B. Anderson (Exeter) outpointed K. G. G. Taylor (St. Mary's).

Bantam-weight.—A. Teuton (St. Mary's) outpointed W. M. Isola (Pembroke).

Light-weight.—D. Hull (Westminster) outpointed T. J. Harvey (Exeter); T. Glanville (Bart.'s) outpointed A. M. Coates (B.N.C.)

Welter-weight.—J. M. S. McCoy (St. Thomas's) outpointed M. Schute (Exeter); S. F. A. Westgate (Guy's) beat A. M. Shaw (Magdalen) in third round.

Middle-weight.—C. H. Kinder (Guy's) outpointed A. C. Johnstone (B.N.C.).

Light Heavy-weight (Cruiser).—L. Kramer (Hertford) beat B. Miller (St. Mary's) on points after a very close contest.

Heavy-weight.—B. W. Cole (B.N.C.) easily beat J. L. C. Whitcombe (St. Mary's) in second round.

Hospital Information, etc.

Notices

YORK CLINIC, DEPARTMENT OF PSYCHIATRIC MEDICINE, GUY'S HOSPITAL.

Applications are invited from qualified medical practitioners unfit for service with H.M. Forces for the full-time post of Assistant Medical Officer in the York Clinic, established for the diagnosis, investigation and treatment of any form of functional nervous disorders or non-certifiable mental illnesses.

The post is graded B 1, and salary will be at the rate of £500 per annum with full residential emoluments.

The appointment will be for a period of six months in the first instance, but will be extended for a suitable applicant.

Applications should be sent to the Secretary of the York Clinic, Counting House, Guy's Hospital, S.E.1, not later than the 18th April, 1945.

NATIONAL PROVINCIAL BANK, LTD.

An office of the National Provincial Bank, Ltd., is open for the convenience of the Hospital staff and students, in the Counting House of the Hospital. Mr. J. C. Carlisle, the manager, will welcome enquiries from members of the staff and students at Guy's requiring banking facilities. Hours of Business—Week days: 10 a.m. to 12.30 p.m. and 1.30 p.m. to 3 p.m. Saturdays: 9.30 a.m. to 11.30 a.m.

Pass List

CONJOINT BOARD.
FIRST EXAMINATION.
March, 1945.

Anatomy.

M. P. Cardew — J. T. Cecil
R. S. Wilson

Physiology.

E. Killey — T. G. Pugh

Pharmacology.

J. H. Apted — R. L. Edwards
H. Herbert — J. T. Woodall

CONJOINT BOARD.
PRE-MEDICAL EXAMINATION.
March, 1945.

Chemistry.

E. J. Annen — P. Griffiths
R. D. Baker — J. D. Horsley
D. G. Brett — D. J. Murch
D. G. Bunker — K. M. Walker.
W. Finkel — M. Woolf

Physics.

R. D. Baker — H. A. H. Ohlrich
R. G. Fricker — P. H. Tucker
B. A. Hill — P. J. Wright
E. D. Morgan

Elementary Biology.

R. G. Fricker — P. H. Tucker
P. Griffiths — K. M. Walker
J. D. Horsley — M. Woolf
D. J. Murch — P. J. Wright
H. A. H. Ohlrich

Papers by Guy's Men

Howitt F. D. The Correlation of Medical Science and Physical Education. *J. Royal Army Med. Corps*, 1945, **84**, 85.

Herbert, W. E. A correlation of the clinical signs and symptoms, and histological condition of the pulps of fifty-two teeth. *Brit. Dent. J.*, 1945, 78, 161.

Leader, S. A. Glass fibres as Acrylic Strengtheners. *Dent. Gaz.*, 1945, **11**, 255.

Matthews, E. Some common causes of failure in dentures. *Ibid.*, 258.

Wallis, C. D. Dentistry as a career. *Ibid.*, 259.

Harding, H. E., and Others. Iron Oxide dust and the lungs of silver finishers. *Lancet*, 1945, i, 337.

Forman, L. V. Verrucose dermatitis of amputation stump. *Proc. Roy. Med.*, 1945, **38**, 145.

Morgan, O. Gayer. Retinitis circinata of unknown origin in a child *Ibid.*, 168.

Change of Address

A. W. Banks (336145), Lieut., R.A.M.C., Draft R.C.F.W.F., E. Africa Command.

E. C. Beale, F.R.C.P., Derwent House, Beauchamp Avenue, Leamington Spa.

J. D. Buxton, Captain, R.A.M.C., 115 (Br.) General Hospital, B.L.A.

R. M. Corker (81302), Ft.-Lt., R.A.F., R.A.F. Post Office, S.E. Asia Air Force.

G. Ebbage (7174), Major, R.A.M.C., 43 General Hospital, M.E.F.

Miss S. A. Irvine, Q.A.R.N.N.S./R, Permanent Naval Staff No. 11, S.S. *Strathlaird*, c/o G.P.O., London.

Award

M.B.E.

Herbert Stanley Knight has been appointed M.B.E. for brave conduct in Civil Defence.

Birth

BRAIN.—On 27th February, 1945, to Irene, wife of F. H. Brain, at the Summer Court Nursing Home, Southborough, Kent—a son.

Marriages

DUNN—APPLEBY.—On January 15th, 1945, at West Tarring, Sussex, Captain J. R. Dunn, R.A.M.C., to Joan M. A. Appleby, A.R.R.C., T.A.N.S.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1480 *14th April, 1945* *Ninepence*

PASSIM

THE spring-tide of Allied victory floods over a collapsing Germany. The War, which started as a crusade against the ideology of Fascism, finishes—a conquest of Germany. Victory will be absolute when we have divested ourselves of the chainmail of autocratic control, whose chafing weight we assumed in the dark hours of need. Meanwhile, Victory Day and its exact location in time presents a perplexing problem. Once the armchair dictum: "Germans? They're all the same. Crack his hard outer surface of resistance and the Hun's beat!" was self-reassurance in which it was comfortable to indulge. But now it is time to face reality. Crack a hard outer surface and you get, logically enough, a number of hard fragments. These fragments may well have to be split and pulverised in turn, before their residual dust of Nazidom can be completely cleansed away. As General Eisenhower seemed to imply in his recent statement, Victory Day, when it is announced, may well be a token celebration of the "all over bar the shouting" stage rather than of the absolute cessation of hostilities.

For the medical student and for the newly-qualified it may be a token celebration in another sense, too. While his qualified seniors have been serving in the Forces or have been shouldering the burden of outsize war-time practices, the medical student has been constrained to play the part of the civilian at war. In this role he may have volunteered eagerly for the L.D.V.—and groused in the Home Guard; he may have bought War Bonds and given money freely to the Exchequer for no more surety than a few pints of waterish extract of hops; he has extinguished his quota of firebombs; and he can recount his own story be it of bomb, buzz or rocket; his clothes have at times reached a state of patriotic dilapidation that has even aroused the curiosity and comment of his teachers. In short, he has but shared the lot of nearly every other civilian in the land. On rare occasions only has the medical student been able to feel himself a useful part of the nation's war machine in his own right; when he has been summoned to Front Surgery or the theatres to assist with the dusty bloody bodies of air-raid victims; when he has travelled to the invasion ports to receive service casualties; when he has gone down to Dover during the shelling as a member of a surgical team. In general, however, the War has merely meant getting through examinations in a rather shorter time than usual.

Meanwhile fighting against hard opposition continues in the Far East, but even if it should soon cease there, war will not have passed us by. Long ago, in the age of chivalry, after armies had fought one with another, there would be a truce when the dead were buried and the wounded were gathered in and tended. Now, the battlefield is all Europe; and while the battles draw to a conclusion, the doctor's work increases to a crescendo; already the camps are being set up in this country to feed and clothe starving children from the Netherlands; already volunteer medical students have been asked to hold themselves in readiness for dispatch to the Continent on relief work. No; the War has not passed us by.

WE regret to have to say farewell to Mr. D. M. Jackson, who is leaving Guy's to join the Army. We welcome, in his place, as surgical tutor, Mr. R. L. Canney, coming to us from the Royal Victoria Hospital, Newcastle-on-Tyne. Mr. Canney has been invalided out of the Royal Navy.

THE Dramatic Society proposes to give us more entertainment in the near future. On April 26th they are presenting "Rope," a play by Patrick Hamilton, which was successfully performed by the Society down at Tunbridge Wells. The caste for this new production is not substantially altered.

Retirement of Mr. F. N. Doubleday

ON March 5th, 1945, Frederick Nicklin Doubleday retired from the Staff of the Hospital and School on reaching the age-limit. In October, 1905, he entered the schools at Guy's as a third year student from Manor House School, having passed what was then called the First Conjoint, from Birkbeck College. He had also completed his preliminary training in dental mechanics.

He had a successful career as a student, taking his diplomas of L.D.S., and M.R.C.S., L.R.C.P., and was appointed a Demonstrator in the Dental School.

After a short period in this capacity he was appointed Tutor of Revision Classes, and immediately, began to show his great capabilities as a teacher. He established a reputation which increased from year to year, and was successively Lecturer on Dental Materia Medica and, for the last ten years, Lecturer on Dental Surgery. He was greatly interested in the antiquities of Guy's with special reference to Keats.

His final lecture, given on March 20th, was entitled "Dental Teaching at Guy's Hospital from 1795 to 1895" was a brilliant survey of the brilliant surgeons in charge of this specialty during the period. This lecture, which completed forty years' uninterrupted association with the Hospital, was a fitting finale to the career of one who will always be remembered as one of our great teachers. G. B. P.

Earache

By W. M. MOLLISON, C.B.E., M.A., M.Chir., F.R.C.S.,

Surgeon, Ear and Throat Department, Guy's Hospital.

EARACHE is a symptom most persons suffer from at some time of their lives and one certainly that every practitioner is called on to treat sooner or later; it varies from an occasional twinge, perhaps recurring at intervals over long periods, to most severe paroxysms of sudden onset preventing sleep and demanding immediate relief; unless the cause be discovered, treatment will not be adequate.

Earache is a broad term to include pain in or about the ear; pain due to some affection of the ear itself may be called *otodynia* and pain referred to the ear from affections of neighbouring or distant organs is called *otalgia*. In other words, *otalgia* implies pain in the ear with absence of any discoverable abnormality on examination. Of these two groups—otodynia and otalgia—the former comprises far the larger number of cases, but the latter, though small, is really of greater interest, since diagnosis is more subtle and involves a rather wider view of the patient than is obtained by looking down an aural speculum. These two groups will be now considered.

OTODYNIA.

To discover the "local" cause of earache it is necessary to examine the auricle, meatus, tympanic membrane, and the surrounding parts of the ear, mastoid process, and the scalp above and behind the ear. A detailed account of the causes is not possible; most are given in the table below, but a few points may be mentioned. The majority of causes are inflammatory; in the skin, streptococcal infections, ulcerations, traumatic or neoplastic, also occur. . . . To discover an early boil in the meatus may not be easy, but pain on drawing the auricle in different directions is a helpful sign and the use of a probe may discover a small tender spot in the meatus. A tender and palpable gland or the presence of lymphangitis with œdema over the mastoid process may result from a boil in the posterior meatal wall or from a septic spot in the scalp above the ear as high as the middle line; and a tender gland in front of the tragus points to a boil in the anterior meatal wall. The tympanic membrane must be examined for any departure from its normal pearly colour: even redness along the handle of the malleus may indicate an early otitis media as the cause of earache, especially when combined with diminished hearing. Hæmorrhagic blebs on the meatal wall or/and on the membrane should be noticed since they cause much pain. In the presence of otorrhœa, due to acute or chronic otitis media, pain and tenderness over the mastoid process suggest that pain is due to mastoiditis.

Earache frequently occurs in aviators, owing to differences in pressure within the middle ear and the surrounding atmosphere: normally the pressures within and without are kept equal by air passing along the Eustachian tube into or out of the middle ear according to the differences of atmospheric pressure, especially on swallowing. Air passes out of the tube more readily than into the tube. In consequence of the rapid descents of modern fighting planes, very great pressure is exerted on the outer surface of the tympanic membranes and, unless air can pass up the tube, the membrane is driven inwards; this causes much pain. This condition is called aural barotrauma. Treatment obviously must be directed to inflation of air into the middle ear *via* the Eustachian tube.

The following table shows the causes of pain in both groups—otodynia and otalgia.

CAUSES OF EARACHE.

LOCAL—OTODYNIA.	REMOTE—OTALGIA. (Pinna, meatus, membrane and parts round ear normal).
Pinna:	
Trauma.	
Erysipelas	
Frost-bite.	
Gout.	*Referred Pain* from parts supplied by the nerves which also supply the ear.
Perichondritis.	
Rodent ulcer.	*e.g.* Vth cranial nerve.
Epithelioma.	VIIth ,, ,,
Herpetic vesicles.	IXth ,, ,,
	Xth ,, ,,
Meatus:	
Wax.	
Foreign bodies.	
Furunculosis.	Second and third cervical nerves.
Boils.	
Hæmorrhagic blebs.	*Neuralgias* from posterior-root inflammation with or without herpes.
Rodent ulcer.	
Tympanum and Membrane:	
Aural Barotrauma.	Second and third cervical nerves: Herpetic spots in the scalp, above and behind the auricle.
Acute and chronic inflammations.	
Hæmorrhagic blebs.	
Primary carcinoma of middle-ear.	Herpes auris, spots on concha, sometimes facial paralysis, deafness and vertigo.
Secondary carcinoma.	
Mastoid Process:	
Glands enlarged as result of scalp infections.	Glossopharyngeal neuralgia, herpetic spots on tonsil or/and palate.
Lymphangitis.	
Mastoiditis.	

The proportion of cases of otodynia to those of otalgia is, roughly, nineteen to one. When all local causes of earache have been excluded the case is one of otalgia.

OTALGIA.

Pain is produced in two ways:—(1) By referred pain, from irritation of the nerve endings of the distant distribution of the nerves which also send branches to the ear. Why pain from a distant area should be referred to the ear is not clear; it has been suggested that—(*a*) it is due to mistaken localisation by the cortex of the brain; (*b*) it may be a matter of faults of experience, *e.g.* infants cannot refer pain to the affected area. Even adults find difficulty in deciding exactly where pain is originating, *e.g.* pain due to an upper tooth may be felt to be in a lower one; (*c*) in the case of the ear, owing to the free anastomosis between the nerves, stimuli are referred to wrong areas of supply; (*d*) in their passage to the cortex the different nerves sent out collaterals which make connection with other fibres to the cortex; so that impulses can take the collateral tracts instead of the main one. This may be the best explanation of referred pain, the collateral tracts only coming into play when painful impulses are being conveyed.

(2) By some affection of the posterior roots of these nerves; the neuralgia is often associated with a herpetic eruption over the terminal distribution of the nerves.

A brief consideration of the anatomy is helpful. The nerve supply of the auricle and the meatus and membrane is by branches of the Vth cranial nerve and the auricular branch of X. The Vth or trigeminal supplies the whole face, the upper and lower jaws, including the teeth, also the nose. The IXth or glossopharyngeal supplies the tympanum and is distributed to the Eustachian tube, naso-pharynx, tonsil, back of the tongue, pharyngeal wall and lingual aspect of the epiglottis. The vagus nerve has a wide distribution, but the superior laryngeal nerve supplying the ary-epiglottic folds and larynx is the only branch of importance here. The VIIth or facial nerve has been stated to have a sensory distribution to the concha through the *pars intermedia*

of Wrisberg, and there is clinical evidence in its favour. The auricular branch of the vagus also supplies the posterior part of the concha. The cervical plexus through the great auricular and small occipital nerves supplies much of the pinna.

When investigating a case of otalgia, the exact localisation of the earache may assist in determining its source: the pain may be in the pinna, the meatus, or deep in the ear; sometimes it is in front or behind the ear. John Hilton, in his "Rest and Pain," gave several instances of the importance of the exact localisation of pain.

In one case pain was felt in the lobe and was found to be due to pressure by an inflammatory gland on the great auricular nerve. The gland suppurated and was opened; at once the pain disappeared.

Similarly pressure by, or actual involvement in, secondary malignant glands may cause severe pain in the ear. Since irritation of any of the areas of supply by these nerves is capable of producing pain in the ear, it is fairly simple to enumerate the causes of referred pain. Actually the first division of the Vth nerve rarely gives referred earache: the second division sometimes: whereas the third division commonly gives rise to earache. The whole upper respiratory tract must be passed in review in searching for the cause of referred pain since the Vth, IXth and Xth nerves supply sensation to a wide area and to the ear as has been shown. Examination must include teeth, tongue, tonsils, palate, nasopharynx, pharynx, epiglottis, hypopharynx, or deep pharynx and larynx. These may now be considered in detail.

Teeth.—Caries and maleruption of the teeth in the lower jaw are common causes of pain in the ear; the pain is referred to the homolateral ear and only exceptionally to the contralateral ear. In the absence of caries, the third molar if unerupted must be suspected. An X-ray examination will demonstrate its position; usually it will be found lying horizontally with the crown pressing against the second molar. Extraction of the offending tooth cures the earache. Perhaps rubbing the ears in the case of infants is due to discomfort from erupting teeth.

Tongue.—Ulceration and new growth of the tongue often cause referred pain in the ear—traumatic from rough teeth, tuberculous, that of Vincent's angina and that of malignant disease. When the lesion is on the lateral part the trigeminal nerve is responsible; when on the posterior surface the glossopharyngeal.

The Tonsils.—It is a commonplace that acute tonsillitis is accompanied by discomfort in the ears and that quinsy causes severe pain in the ear; after the operation for removal of tonsils earache is common during the first few days or not till the fourth or fifth day after operation. Streptococcal ulcerations of the tonsil and Vincent's angina, and those rare cases of tuberculous ulceration all cause otalgia, and so does carcinoma and in a severe degree. Indeed, on one occasion the earache was so severe from a carcinoma of the palate and tonsil that injections of alcohol into the third division of the Vth nerve at the foramen ovale had to be given. But beyond these fairly obvious lesions, lesser ones must be sought, such as tonsillar abscess left after some tonsillar infection and showing but little on casual examination. These small abscesses show only as a smooth soft area on the surface of the tonsil often paler than the surrounding tissue; on pressure it may be possible to express pus, more often a prick with a sharp knife will be needed to allow egress of pus, with immediate relief of earache. Even retention in a crypt may give earache. Such was the case in a man who had complained of intermittent pain in the right ear for nine months. Fortunately he had an attack during examination; in the search for a cause, pressure on the right tonsil expressed a considerable plug of debris from a crypt in the posterior part of the tonsil with immediate relief of the earache.

Pressure on the tonsil by a long styloid process may cause earache and, indeed, cases are recorded in which removal of a piece of this process has cured earache.

Palate.—Inflammation and œdema of the soft palate, accompanying peritonsillitis or as the result of acute inflammation after removal of the tonsils, tuberculous ulceration, and epithelioma are causes of earache. Asymmetry should be noted. One side may be pushed forward by a growth in the nasopharynx. The presence of spots on one side of the soft palate suggests herpes and such spots are more the result than the cause of earache, since they occur with glossopharyngeal neuralgia.

Nasopharynx.—Examination may reveal the presence of growths in the neighbourhood of the Eustachian tube, either carcinoma, sarcoma or fibroma. It should be remembered that in young persons (under twenty-five) the nasopharynx is more frequently the site of carcinoma than almost any other part of the body. Pus may be

seen coming from the posterior nares giving evidence of sinusitis, and this, too, must be noted as a cause of referred earache through the glossopharyngeal nerve which supplies the sinuses.

The Pharynx and Larynx may be grouped together, since the view with the laryngeal mirror includes both, and may reveal acute inflammations or ulcerations, generally streptococcal, or tuberculous ulcerations, of the epiglottis or arytenoids, growths of the deep pharynx, ary-epiglottidean folds or pyriform fossæ. It is true these conditions also cause pain on swallowing, but occasionally pain in the ear is the only symptom. Aneurysm of the internal carotid is stated to cause earache, perhaps through the sympathetic twigs on the artery. Acute inflammation of the deep lateral pharyngeal wall causes intense earache.

The Nose.—Anterior rhinoscopy should be carried out as it may reveal pus due to sinus suppuration or congestion of the mucous membrane, suggesting acute sinusitis which causes earache. A mass of growth may give the key to earache.

After this "internal" examination, external structures must be noted; enlarged glands in the neck, septic, tuberculous, or malignant. The parotid gland and the temporo-mandibular joint; this latter is supplied by a twig from the auriculo-temporal and, in consequence, arthritis may be the cause of earache. Lastly, general examination may disclose high blood-pressure, some general nervous disease, *e.g.* tabes in which earache may be associated with degeneration of the *pars intermedia* of Wrisberg. A history of gout may be obtained and suggest the cause of pain in the pinna; tophi may be seen on the edge of the pinna. A percentage of cases of facial paralysis (Bell's palsy) suffer from earache.

Neuralgia of the cutaneous nerves which arise from the posterior roots of the second and third cervical nerves causes much pain in the ear; and herpes which may not come on till the pain has been present three or four days, occurs on the scalp above and behind the pinna as well as on the lower part of the pinna. Diagnosis in the early case before any spots have appeared is difficult; severe afebrile pain in and around the ear with normal hearing and normal meatus must suggest a neuralgia. Post-herpetic pain is severe and persistent in some cases. Lastly, the neuralgia of geniculate herpes, sometimes called *herpes auris*: in this disease, pain is centred in the concha, on which herpetic spots appear; facial paralysis is not constant, but frequent. In some cases deafness, in others deafness and vertigo, accompany the paralysis. Since there may be an enlarged gland over the mastoid, tenderness here may arouse the suspicion of inflammation in the middle ear and mastoid: a normal membrane and normal X-ray of the mastoid should lead to the correct conclusion.

NEURALGIA.

Neuralgias from posterior-root inflammation of the nerves which send branches to the ear cause severe earache and may be accompanied by herpetic eruptions on the skin supplied. Trigeminal, glossopharyngeal, or second and third cervical are the neuralgias to be considered.

Trigeminal neuralgia seldom attacks the ear only; it usually involves the whole of one or two divisions of the Vth nerve, and the earache is only a small part of the pain; and herpes on the ear is so rare that it is doubtful if it occurs.

Glossopharyngeal neuralgia, on the other hand, gives rise to severe earache, but is, fortunately, a comparatively rare disease. If herpes accompanies the neuralgia it is found on the soft palate or tonsil. The pain begins suddenly and is concentrated in the tonsil area and at the back of the nose on the upper surface of the soft palate as well as being referred to the ear.

In one case the pain began while the man was smoking a cigarette and persisted in spite of all treatment; in another, the spasms of pain were so severe that the victim had to sit very still holding her head towards the affected side and supporting it in her hand.

The only treatment of any value in severe cases lies in avulsion or intracranial section of the glossopharyngeal nerve.

TREATMENT.

Treatment of a patient with earache depends on treating the cause as far as possible. Any local inflammatory condition may be treated by drops of glyc. acid. carbolici. If the case be one of meatitis a culture may be made; if, as is generally the case,

Staphylococcus aureus is found, local applications of a 10 per cent. solution of silver nitrate on alternate days combined with drops of ung. hydr. nitrat. dil. 60 grains, ol. amygdalæ ad. 1 oz. three times a day. Should, however, *B. pyocyaneus* be found, applications of 8 per cent. solution of aluminium acetate give relief.

Actual boils may be opened as soon as it is thought that pus is present; hot applications to the ear by means of a small electrically-heated pad generally relieve pain.

In cases of referred pain removal or treatment of the exciting cause is clearly indicated, carious teeth and unerupted wisdom teeth require appropriate filling or extractions.

Tonsillitis calls for the usual treatment. Pain after removal of tonsils is best countered by insufflation of finely-powdered aspirin or even orthoform on to the tonsillar beds. Malignant growths demand surgical or ray treatment by deep X-rays or radium. Lastly, cases of pain due to neuralgia, with or without herpetic spots, must be treated symptomatically, with analgesics—aspirin in mild cases: hypnotics and even morphine in severe cases. For the post-herpetic neuralgia, which may persist a long time, a mixture containing quinine hydrochloride 1 grain and phenacetin 5 grains three times a day is often successful. In very severe and prolonged cases of neuralgia operative treatment to divide or avulse the nerve may be called for.

The Burning Question

By H. St. H. VERTUE.

WHEREWITHAL shall a young man cleanse his way? Or make straight his way, if you adopt the *corriget* of the Latin heading in the Prayer-book. Our fathers thought that if the young man's way was to be that of wisdom and learning, they could help him along it by separating him from women for the time being. So from schools and universities and houses of learning women were virtually excluded. Now this would not have been done unless women had been of a different sex; therefore, in discussing any such question as, "Should women be admitted as students to the same hospital as men?" one is bound to make sex a fundamental issue. In dealing with sex there are two good rules—to do it honestly and to do it as well as one can. Sometimes, when I am going to tell students anything about sex, I mention the fact, so that anyone can go away who likes: no one ever does go. Addressing a possibly wider audience I extend a like courtesy to them.

I should say then that the method of separating the sexes does undoubtedly work. But has it any demerits? Sometimes, at any rate, it has one. A famous example will show what I mean. About a hundred years ago a man of high character and fine intellect, a poet of the first rank, set forth in verses that at their best are of Horatian conciseness and far more than Horatian intellectual content certain fundamental questions that perplexed mankind then and perplex him still. But along with these verses were others of a more sentimental kind, bewailing the death of a young man in terms that would have been more properly addressed to a young woman:—

"Dark house, by which I used to stand
Here in the long, unlovely street,
Doors, where my heart was used to beat
So quickly, waiting for a hand,

A hand that can be clasped no more—
Behold me, for I cannot sleep,
And like a guilty thing I creep
At earliest morning to the door."

In lines like these and in many other similar passages an actual physical affection peeps out from the passionate regret; and in all the elegiac parts of the poem there is an extraordinary idealization of the lost youth. One reviewer, it is said, spoke slightingly of him as an Amaryllis of the Chancery Bar! Yet Tennyson did not perceive that there was anything peculiar in his poem, nor did the public. It is not that Tennyson is to be suspected of anything outrageous, but that he very nearly cut himself off from a number of things that are necessary to a man, if his life is to come to full fruition. Perhaps it was as well for him that Arthur Henry Hullam died when he did. Release came in time in the remarkable dream portrayed in Canto CIII.

Maidens, playing on the harp and carolling, bore him to a great ship, where the beloved youth was on deck. Climbing up, he fell upon the beloved's neck; whereupon the maidens with one mind bewailed their lot. The man he loved addressed them, "Enter likewise ye and go with us." In Canto CXIX he visits "the doors" again. Now he avers :—

"And in my thoughts *with scarce a sigh* (italics mine)
I take the pressure of thine hand."

I unfold this story because it tells how a man educated in the way I mention may erroneously bestow upon one sex the things that belong to the other. Tennyson was robust and bisexual; he attained to a normal reaction at last as the dream tells. Others are not so fortunate; their disablement is always with them. Such men may sometimes be known by their high-flown style, excessively æsthetic outlook, religiosity and lack of humour. Sometimes it seems as if the emotions of sex, half unused, run off into prolixity and too exuberant fancy, at others, into extreme preciosity and arduous refinement of style. Sooner or later the true state of affairs is revealed. From the internal evidence of their work it is impossible not to conclude that J. A. Symonds and Walter Pater were such men; and there are others, too. Examples in daily life may occur to anyone.

In ancient Greece this disorder among intellectual men, who cut themselves off almost altogether from the society of women and generally despised them, was far more troublesome than it is here: the sublimations accomplished by English writers did not by any means always occur. He who, with his eyes open, reads Plato for the first time may get a surprise here and there. But when all is said and done the thing is not a serious menace here; nor is it at all confined to public school and university men. According to Havelock Ellis it is common among waiters and hairdressers. Still, if any system of co-education is to be scrutinised, it is only right to bring this matter out into the full light of day. In short, the risks of promoting homosexuality by segregating the sexes during education may not be very great, but they are there.

This is the only serious disadvantage that I can think of in the time-honoured practice of setting the sexes apart. Is there anything amiss with bringing them together? There is. Suppose we consider the matter from the point of view with which we are now most concerned—that is, the mingling of men and women students in a hospital.

Any reason but the real one is usually brought forward by men when they object to the admission of women students, as for instance that they would crowd round the bed too much and obstruct the men, or that it would be difficult to teach them certain subjects or tell certain anecdotes that drive the point home to the student, unimportant things, evasions that cover the real issue because on it there is a taboo, one however that it is quite easy to lift. Into the boiling currents (*freta*) of youth, says a great poet, seed first makes its way when the ripeness of time has matured it in the members; then come the images from whatever body it may be, harbingers of a glorious face and a beautiful hue :—

"nuntia praeclari vultus pulchrique coloris,
qui ciet irritans loca turgida semine multo."

He goes on to describe the effect :—

"fitque voluntas
eicere id quo se contendit dira libido,
idque petit corpus, mens unde est saucia amore."

But why *dira libido*, one asks; why "fell desire"? We shall see. He clinches the matter :—

"unde feritur, eo tendit gestitque coire
et iacere umorem in corpus de corpore ductum."

This is Venus for us, he says; thence is the name of love; thence yon drop of Venus' sweetness first trickles into the heart. And if that is absent which thou lovest, yet the images thereof are at hand and the sweet name hovers in the ears.

"Haec Venus est nobis; hinc autemst nomen amoris,
hinc illaec primum Veneris dulcedinis in cor
stillavit gutta . . . .
nam si abest quod ames, praesto simulacra tamen sunt
illius et nomen dulce obversatur ad auris.

But it is meet to flee from the images and scare away the sustenance of love and turn the mind firmly elsewhere.

"sed fugitare decet simulacra et pabula amoris
absterrere sibi atque alio convertere mentem."

Here, then, is the earnest advice of Lucretius, foremost as poet, scientist and philosopher, who united in himself in a manner unsurpassed a scientific imagination that often leapt forward two thousand years ahead of its time, a philosophy the most reasonable, the most satisfying and the most in accord with scientific teaching, and a divine poetic gift, the honey of the Muses, to sweeten the draught of wisdom; who spoke to us in one of the noblest of tongues, the language of ancient Rome; who was a master beneath whose hand the great hexameters come rolling up like billows on an ocean beach, falling in majestic subsidence, the foam running down their backs, one after another in orderly array. To a man of this calibre art, science and philosophy are things that occupy the whole of the attention. Venus is a very noble goddess: to her he dedicates his poem; but the same head will not hold Venus and Minerva *at the same time.* What right then has anyone to ordain that young men who are treading the path of learning should be continually subjected to sexual stimulation? These are for them the formative years; these are the days when the foundations of culture are to be laid that last through life; if the foundations are amiss, all is awry. Ground lost now will never be regained; tastes unformed will be formed with difficulty or not at all; things unlearned will be much more difficult to learn. Happiness, tranquillity of mind, judgment, independence of thought, knowledge of the best, depend upon nothing so much as a first-rate education. There is a long stretch to come: surely Venus can wait a while upon Minerva. Why, the man who has qualified is mostly on the right side of twenty-five. What, one asks, is the sense or the humanity in attempting to force one sex upon another to its detriment? A hospital is no mere training college, where licences are granted to take fees from the public upon passing an examination. It is part of a university, a place where wisdom and learning are taught, where character is formed; and if ever it is not these things, then it ought to be.

"Sed nil dulcius est bene quam munita tenere
edita doctrina sapientum templa serena."

But nothing is sweeter than to hold the serene courts of the sages, lofty, well furnished with learning. But I say, too, that a man must set foot upon the path that leads to those clear courts while he is still young, and that nothing ought to be done to obstruct his ascent.

It would be useless to say that women would not purposely disturb the men, for some would surely do so, tempting him to run the course of love and seek a common joy. The greater number I readily admit would not, but their femininity alone would suffice, "*mulier toto iactans e corpore amorem.*" The oval hands, the taper fingers, the well-rounded curves of the body, the oblique set of the ears, tendrils of hair, soft dulcet tones, the very fragrance of a healthy young woman, all these things are powerful excitants when the tide of youth runs strong.

"Light feet, dark violet eyes, and parted hair;
Soft dimpled hands, white neck and creamy breast,
Are things on which the dazzled senses rest
Till the fond, fixed eyes forget they stare."

So wrote a scion of Guy's in 1817. If Keats felt like this why not others? But older men forget "the boiling currents." Possessed by some philanthropic motive or some mistaken sense of generosity towards the other sex they urge the claims of that one oblivious of what is due to their own. Mistaken, too, because women have an equal right to be left alone if they so desire. And here is a very curious fact: there is a movement to force women upon men, but none anywhere that I have heard of to force men upon women. Of course, none worthy of the name would go. That students do in the main object to the idea of this feminine intrusion I have no doubt. The thought is somewhat inarticulate—how could it be anything else?—and seems not to have reached the stage of a reasoned proposition, but rather to remain what is loosely called an instinct. Call it what you will, it is perfectly sound. Is it not a fact that one hospital which had admitted women students had to institute the system called "quota," because the proportion of men ever fell and that of women ever rose?

If what I have said is true, it must follow that the men who mean to do best will go to those hospitals where there are men only, and women with the same intentions to places where there are none but women. If there are mixed hospitals, they will

attract the mediocre. Any hospital, therefore, which wishes to get the best type of student will confine itself to one sex alone. Of course, this is a general truth only. Some men of the best type may deliberately seek the company of the female, and others may not notice her when she is there. Then, again, the most unpromising material may resort to the most august seat of learning. A Welsh bard has recently delighted us :—

"My brother went to Oxford
To take Matriculation ;
He found a pretty barmaid
And never left the station."

What could be done with a man like that ? Still, not theory only but knowledge and experience of life also teach us that men of the best kind do, in fact, avoid and not seek the company of women when they are taking part in the strenuous process of first-rate education. At a place where I spent some years getting educated there was a tribe that did not observe this practice. They were called "poodle-fakers," and, frankly, they were very little use either at work or at athletics. I go there sometimes still. Poodle-faking still goes on and the poodle-faker seems to be a fixed variety, breeding true. I have seen hopes of a fine degree brought to nothing by a premature falling in love, and—mark this, I beg you—I have more than once seen a young woman's education just as much spoilt as a young man's—only in her case it does not matter quite so much, if she marries. One must admit that here and there among the poodle-fakers appears a man of a more virile type, but he is much in the minority ; and with all exceptions duly noted the fact remains that the best men do desire not to be disturbed by women at the time that they are most actively learning ; furthermore that this desire is sound physiologically, is creditable and ought to be respected.

Finally, we must consider those who for long have been so inured to the company of women that they have grown utterly used to them ; the stimulus is there, but no longer is a response called forth. The contention might be made that such men were in a fortunate position, because in them the basic functions of sex might be carried out without the disturbance of falling in love.

"Nec Veneris fructu caret is qui vitat amorem,
sed potius quae sunt sine poena commoda sumit."

And he does not miss the fruits of Venus who avoids love, but rather enjoys the advantages that are without any penalty. Nevertheless he is not a man at all to be envied in my view. The precious process of falling in love is a comparatively modern discovery. The ancients really had rather limited ideas on the subject. To forfeit it is to forfeit a privilege. Novelty, strangeness, unfamiliarity are essential to it. The feelings of wonder and romance that belong to it do not arise from too familiar objects. To dilate upon the subject of falling in love "would seem in me t' affect speech and discourse." Nevertheless, would it not be generally agreed that this is one of the crowns of life ? Would there not be many to say that it is the most precious, the most beautiful of all ? Therefore any system of education that so blunts and annuls the feelings of the sexes for each other that they no longer fall in love or only do so dully and tamely, is one to be condemned.

"Then forth he called that his daughter fayre,
The fairest Un', his onely daugter deare,
His onely daughter and his onely hayre ;
Who forth proceeding with sad sober cheare,
As bright as doth the morning starre appeare
Out of the East, in the flaming lockes bedight,
To tell that dawning day is drawing neare,
And to the world does bring long-wished light,
So faire and fresh that Lady shewd herselfe in sight.

So faire and fresh, as freshest floure in May ;
For she had layd her mournefull stole aside,
And widow-like sad wimple throwne away,
Wherewith her heavenly beautie she did hide,
Whiles on her wearie journey she did ride ;
And on her now a garment she did weare
All lily white, withoutten spot or pride,
That seemd like silke and silver woven neare ;
But neither silke nor silver therein did appeare.

The blazing brightnesse of her beauties beame,
And glorious light of her sunshyny face,
To tell were as to strive against the streame :
My ragged rimes are all too rude and bace
Her heavenly lineaments for to enchace.
Ne wonder ; for her own deare loved knight,
All were she daily with himselfe in place,
Did wonder much at her celestial dsight :
Oft had he seene her faire, but never so faire dight."

It ought to be like that ; and nothing like that was known at least until the Middle Ages. It is *our* privilege. I maintain that if youth will but wait a while, or—far more likely—if its elders will but let it wait a while before commingling daily and hourly with women, it stands the best chance of winning the double prizes of wisdom and learning and of love, but that the premature mixing of the sexes is likely to rob it of either the one or the other or both.

If what I have written be true the future course should be quite clear. There should be hospitals for men students and hospitals for women students, and there should be hospitals where the sexes are mixed for those who like it. Both hospitals and students should be perfectly free to make their own choice. Those who are so very enthusiastic about co-education can expend their energies in making their own arrangements without molesting others.

Correspondence

PROPOSED MEDICAL METHODS.

To the Editor of the GAZETTE.

SIR,—The democratic principle demands that full freedom should be accorded to the patient, not merely in the matter of choice of doctor, but also in deciding how the chosen doctor shall set about his work. The totalitarian principle that the doctor rather than the patient should direct the investigation and treatment of illness can be circumvented by a simple device which will be expounded in the following paragraphs.

The tariff system already popular at multiple stores and other commercial enterprises, surely the choicest fruits of our democratic civilisation, so different from the wretched regimentation of totalitarian states, can be with slight modification applied to medicine. To illustrate this scheme the following table has been devised to show the charges for various phases of a medical consultation :—

Ten minutes' interview	£0	2	6
For every subsequent five minutes	0	1	0
Taking pulse	0	1	0
Temperature	0	1	0
Respiration	0	1	0
History taking	0	2	6
History taking, if written	0	5	0
Sympathetic interview	0	7	6
Severe interview	0	10	0
Blood pressure :			
Systolic or diastolic individually	0	1	0
Both	0	1	6
Examination of chest :			
Without use of stethoscope	0	1	0
With use of stethoscope	0	2	0
Examination of abdomen, proportional to area, *e.g.* :			
Aldermanic	0	2	0
Dwarf, baby, cachexia	0	0	6
Individual examination of nine regions	0	0	6 each.
Whole adbomen	0	4	0
Jerks :			
Use of jerk hammer—			
One knee	0	0	4
Two knees	0	0	6
Babinski :			
Clean feet	0	1	0
Dirty feet, proportional to odour	2s. to 5s.		
Examination of eyes :			
Without use of ophthalmoscope	0	0	6
With use of ophthalmoscope	0	1	6
Itches :			
Without examining	0	1	0
With examination	0	1	6

These few examples give one a glimpse of how the modern method will work. Let us look at the consulting-room of the unregimented future :—

Patient : " Good morning, Doctor, I'd just like a nice bit of pulse this morning, a good ten minutes and no short time, please, and a blood pressure—the systolic this time. Everyone seems to have the diastolic and I like to be different.

Doctor : " Well, Mrs. Brown, what about a real nice sympathetic interview ; it's a special line this week ? "

Patient : " No, thanks, Doctor. I'll wait for the sales to have that done, but I could do with a nice Babinski test."

Doctor : " Have it your own way, mum. I've got a nice bright light in my ophthalmoscope this week. And what about our new line in blood tests ? "

Patient : " Not this week, thank you ; but I don't mind you looking at my left eye, if you make it half price."

Doctor (hurt) : " Afraid we don't make a lower charge for single eyes."

Patient : " But they do over the way ; ever so go ahead they are."

Doctor (worried) : " Well, just this once I'll do it free."

(Examination is done.)

Patient : " Well, how much do I owe you, Doctor ? "

Doctor : " Ten minutes' interview, two shillings."

Patient : " Oh, Doctor, we've only been eight minutes ! "

Doctor : " No reduction, mum, two shillings ; pulse, one shilling and one shilling for the systolic blood pressure ; and I'll give you the eye free. And it's two-and-six for the Babinski."

Patient : " Oh, Doctor, my feet are lovely and clean. I do call that so unfair. I've been insulted. I'll never come to you again. (Exit in anger.)

It is clear to any unbiassed observer that this method brings with it that complete freedom of doctor, examination and treatment which will be the proudest boast of medicine without Beveridge.

Yours, etc.,
H. F. O.,
G. R. W. N. L.,
H. C. M.

POST-MORTEM INSTRUCTION.

To the Editor of the GAZETTE.

SIR,—The constructive suggestions of your correspondents, whose letter appears in the *Gazette* of March 31st, 1945, with regard to possible means by which teaching at post-mortems might be improved, will doubtless meet with universal approval. I, for one, would certainly wish to associate myself with them.

It has always seemed to me that a better correlation might be achieved between the study of the macroscopic and microscopic appearances of pathological processes if a microscope were provided in a convenient room adjacent to the post-mortem room, where those who were interested might, at any time, examine the sections of tissues removed at recent post-mortems. I understand that this is the practice at another London teaching hospital.

As I have been away from Guy's for some months, it is possible that this suggestion has already been brought forward and acted upon without my being aware of the fact. If, however, this is not the case, I am certain that such arrangements, if they are possible, would be in the interests of all concerned, and would make us the better able to visualise the histological picture when we are studying morbid anatomy in the post-mortem room or the museum.

Yours, etc.,

The County Hospital, Pembury, Kent. G. A. K. MISSEN.

Sport

Rugby

GUY'S *v.* ROTOL (GLOUCESTER).

(*Played at H.O.P. on Saturday, March 17th.*)

Result : Guy's, nil ; Rotol, nil.

Rotol came to Honor Oak Park for the first time with the reputation of being one of the best teams in the West Country, having won seventeen of their twenty games, with 331 points to 36, against strong opponents.

With such an impressive record, Guy's not only knew they were up against a strong defence, but also a team anxious to do well against the conquerors of Mary's. Such is fame.

The first half was slightly in favour of Rotol, but Guy's defensive play surpassed anything we have seen this season. There were frequent kicks to touch from both sides, due to keen marking and tackling, and the backs were never allowed to make much

ground. Outstanding in this direction was C. Vidot, who excelled in long raking left-foot kicks, and was also responsible for holding the ball sufficiently long enough for a timely pass if he could not make headway himself.

The play was fast and open, with Guy's three-quarters getting the ball out to the wings, who were always met with a crashing tackle. Alternatively, Rotol's excellent team work and backing up brought out all the best from Guy's forwards in preventing Rotol's halves, H. Rickards and S. Walden, finding any gap for a score.

On the whole, Guy's backs were more impressive in attack, especially in the second half, when several combined movements collapsed on the wings, on account of the deadly tackling of Rotol's three-quarters, and their forwards always recovered to give a hand on the loose ball. One movement stood out in the second half, when G. Locke slipped past G. P. Billingham and kicked into space; the ball bounced awkwardly, but D. G. Jones gathered and made a grand run and a pass to Pugh. The ball went loose, but Jones picked up and ran to within a few yards of Rotol's line before being forced into touch. From the line-out Rotol returned to the attack and twice in succession Dwyer made timely kicks to touch.

Another fine movement was when D. G. Jones sent Macrae-Gibson away, but Carton-Kelly was tackled as he took the pass. Gray also came in for a lot of work, and although he never made a mistake with his kicking to touch and running through, his unorthodox positioning was a little perplexing to the onlooker.

Towards the end a hot attack by Rotol ended in W. L. Jones crossing the line from a pass by G. Locke, but the referee had already blown for a knock on, and so two evenly matched sides completed an open, sporting and extremely keen game with honours deservedly even.

The Boat Club

Those of Guy's supporters who watched the head of the river race on March 24th, 1945, may feel a little disappointed that the eight dropped to twelfth place; but if this feeling was ever present amongst the crew, it soon gave way to one of pleasant satisfaction in having rowed well.

The start at Mortlake was characteristic of the eight who "took her off" well with a long, firm stroke against a head wind, which persisted until after Barnes Bridge was reached.

From there until Hammersmith Bridge the water was smooth and the crew were able to make the most of it by settling down to a firm paddle; but as soon as the rough water between Hammersmith and Putney appeared the going was not a little heavy and a lack of training began to be felt.

For the last mile the crew slowly lost water in spite of several valiant "tens" and ended with a time of 22min. 53sec.

However, although it may seem to have been a pretty dismal race from this report, it was, in fact, a very encouraging performance considering examinations and other social obligations that had interfered with training.

The Crew.—C. M. Williams (bow), D. Chapman, C. C. Bull, J. A. Bulleid, A. F. Crick, F. de Hamel, J. M. S. Burns, R. T. Lowein (captain), A. Shotts (cox).

Hospital Information, etc.

Change of Address

Frank Cook, F.R.C.S., F.R.C.O.G., 12, Upper Wimpole Street, W.1.

H. J. Croot, Lieut.-Col., R.A.M.C., Medical Directorate, G.H.Q., India.

D. J. A. Alban-Jones, Major, R.A.M.C., D.A.D.M.S., H.Q. L. of C. Sub-Area, B.L.A.

C. V. Kark, S/Ldr., R.A.F., 8th R.A.F. Hospital, B.L.A.

H. M. Kelsey, Major, R.A.M.C., 77, British General Hospital, B.L.A.

Miss N. M. Lee (P/338307), Q.A.I.M.N.S./R. R.F.R.L.C., A.P.O. 8260.

D. F. Mace, F/Lt. (D.), R.A.F., Dental Centre, 2nd T.A.F., Hqtrs. Rear, B.L.A.

C. H. Marshall, F.R.C.S.E., c/o The Mombasa Club, Mombasa, Kenya.

I. G. Robin, F.R.C.S., 86, Harley Street, W.1. (Tel.: Langham 3625.)

D. Rosenberg, Lieut., R.A.M.C., c/o D.D.M.S. H.Q., 14th Army, S.E.A.C.

Eric Smith, Major, R.A.M.C., 71 (Brit.) General Hospital, C.M.F.

Stanley N. Tinkler, Surg.-Lieut-Cmdr. (D.), R.N.V.R., R.N. Base, Gibraltar.

W. H. Trethowan, Capt., R.A.M.C., 23 Scottish General Hospital, B.L.A.

F. D. Turner, M.B.E., 8A, Beverley Road, Colchester.

Dental Appointments

Resident House Surgeon.—N. S. McKie.

Wildernesse and Guy's (Conservation Room).—A. J. Bridge.

Conservation Room.—A. V. M. Campbell Ferrari.

Do., Assistant House Surgeons.—G. B. Pritchard, P. Maxwell Stephens, J. E. Attale.

Orthodontics Department.—B. H. de C. Prideaux.

Do., Assistant House Surgeon.—A. E. Trist.

Prosthetics Department.—A. J. Brunnon.

Birth

BULOW.—On February 16th, 1945, to Barbara Marie (née Stevenson), wife of J. E. Bulow, Capt., R.A.M.C.—a daughter (Patricia Jane).

RUSHFORTH.—On March 10th, 1945, at Guy's Hospital, to Kitty (née Alkin), wife of Arthur Rushforth—the gift of a daughter (Mary Annabel), a sister for Graham.

Marriages

BEVIS—LE MESURIER.—On March 24th, 1945, at Rusthall, Kent, A. W. Bevis, Surg.-Lieut. (D.), R.N.V.R., to Margaret Le Mesurier, W.R.N.S.

GOULDER—OLIVER.—On April 9th, 1945, at St. Mary's, Prittlewell, Raymond Victor H. Goulder to Margaret M. O. Oliver, P.M.R.A.F.N.S.

Deaths

INGRAM.—On March 21st, 1945, at Newport, Mon., Percy Cecil Parker Ingram, M.B., B.S., aged sixty-nine years.

SHEEN.—On March 28th, 1945, at Cardiff, Alfred William Sheen, Provost Welsh National School of Medicine, aged seventy-five years.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1481 *28th April, 1945* *Ninepence*

PASSIM

IN the last few weeks we have seen, epitomised in a few sordid wire-bound acres, the final answer to the question, "What are we fighting for?" This was probably the most significant incident in the War for us in the West; one's subjective feelings defy metaphor and of the objective findings, it has been said that the whole story would offend public morality if given in any other form than a medical report; there seems, then, little more to be said at the present.

THIS edition of the *Gazette*, fortified by no less than four extra pages, is our special review number, our literary supplement. In the last few years books have led a precarious existence; for while literature has not been martyred here as it was in Germany, it has received an inevitable set-back from war. In 1940 for example, it was proposed that books should be subjected to a purchase tax. Fortunately this proposal caused a most vigorous reaction in the House of Commons, where Mr. A. P. Herbert likened it to that infamous piece of legislature, the window tax. It was an apt analogy though not a strictly true one, for in the first half of the last century, anything more than the bare minimum of windows was considered a luxury with which the family retainers if not the family, could dispense; as the bricked panels peering blindly from under the eves of so many Georgian and Regency houses testify: no need to let in sunlight for who had heard of vitamin D? Draughts must be excluded—for who knew of the organisms that shared the hot and humid living-rooms with their human inmates? The leech at the court of Louis XV, who was wont to treat his patients with courses of incantations—to be chanted thrice daily over a stripped willow wand, in front of an open window—was a sagacious man; ventilation was a comparatively unpopular function of windows in those days. But in the twentieth century the value of both the illuminating and ventilating properties of books being well understood, a new "window tax" was avoided; and while the prices of books have risen, this increase has not been disproportionate to that of the cost of living.

The quality of the paper and binding of the wartime book, though often much better than can be expected, has naturally worsened. The illustrations of new books are frequently deficient and the progression of the increasing ratio of picture to print that was a feature of modern text-books has been halted. But paper restrictions have taken greatest toll of size and quantity, for war-time has impressed on those who had not before possessed it, the virtue of conciseness; or perhaps it has merely accelerated a trend. The era of the pocket manual, the extract, the essence, the condensing, squeezing, tabulating age was upon us, with the mass of information held in the particle of printed matter. As for quantity, considerable numbers of new books continue to arrive in the *Gazette* office for review; but without adequate controls one cannot gauge how many gems are hid by "the dark unfathomed caves" of paper restriction. But the unsatisfactory situation concerning the reprinting and re-editing of old favourites is evident enough. The long waiting lists for new, second-hand and library editions of text-books proclaim gross insufficiency.

So it is, that at a time when one cannot walk into the bookseller's and order "this and that and that and A.'s latest—and put them all down to my account" the reviewer, "the man who knows best" should be particularly heeded; for it is his duty to demonstrate the clarity or opacities of our now restricted sources of ventilation and light—books.

OUR readers will want to join us in congratulating Miss S. M. Greaves (Guy's 1932–1936), a sister in Q.A.I.M.N.S., on being awarded the George Medal. When enemy planes bombed and machine-gunned tents two hundred yards away, which formed a casualty clearing station at Anzio, she ran at once and dressed the wounded, while a second wave of bombers came in. "Her prompt action," says the official comment "undoubtedly saved much suffering and hastened the evacuation of the wounded."

THIS announcement of the retirement of two of the Hospital's oldest employees is overdue, for it was in March that Mr. Whitbread and Mr. Warren, who have seen thirty-seven and thirty-two years' service at Guy's respectively, went off the active list. Guy's thirty-seven years ago can be better imagined if we quote Whitbread's own words: "Mr. Hughes must have been R.S.O., and Mr. Layton was in the dissecting-room." The picture opposite shows Whitbread leading a procession of the staff of the Hospital at the ceremony of the opening of the new Pathological Building in 1938. Warren, who came to Guy's in 1913, was foreman of the bluegang of wardsmen. May they both enjoy good health and prosperity for a long time to come!

WE announce with regret the death of Mr. Guy Bellingham Smith, consulting obstetrician to the Hospital. We hope to include an obituary notice in the next issue of the *Gazette*.

The History of Dental Teaching at Guy's Hospital, 1795-1895

BY F. N. DOUBLEDAY, L.R.C.P., M.R.C.S., L.D.S.(Eng.).

GENTLEMEN,—In a course of systematic lectures upon dental surgery the lecturer must lay before you controversies regarding the pathology and treatment of dental disease. He must then, from his own great clinical experience, tell you what he believes to be the facts upon which your practice may be founded most surely. In helping you to form your own judgment in these matters it is of value that one lecture should be devoted to the life and teaching of my predecessors in this lectureship during the past 150 years. In our knowledge of this subject we are greatly indebted to the researches of Sir Frank Pearce. I think it is a defect of our Hospital life that we have no commemoration of the great men who have lived and worked her. Thomas Guy, John Keats, Edwin Cooper Perry, these are names to fire the imagination and stimulate the efforts of their successors. During the eighteenth century the principal teaching in dental subjects was given by the great anatomist and surgeon of St. George's Hospital, John Hunter. He also carried on an extensive dental practice from his house in Golden Square, and in 1778 put into book form the results of his observations as "The Natural History and Diseases of the Human Teeth." Among those who attended his courses was Henry Cline, Senior, who later became Surgeon to St. Thomas's Hospital. One of Cline's pupils was Astley Cooper. He entered first at Guy's as a pupil of his uncle, William Cooper, but his boisterous

nature did not go well with the quiet classical tastes of his uncle. He therefore transferred his pupilage across the street, to the hospital which was named after St. Thomas a Becket of Canterbury, and of London. Another of Cline's pupils was Joseph Fox, who tells us that when at a very early age he was deprived of his father, a dentist, Cline helped him with his advice and transferred to him the confidence of a respectable practice. These young men belonged to the Pupils' Physical Society at Guy's, but in their ardour for scientific knowledge they formed a society, such as we to-day should term a study circle, to further their knowledge. From the Journal of one of their numbers I append three entries from a contemporary diary :—

February 9th, 1799.—To Askesian Society. J. Fox's paper discussed. Rather an interesting evening. W. H. Pepys present for first time and made some experiments on oxygen gas and charcoal.

January 27th, 1800.—There were some experiments on Respiration. Astley Cooper, Dr. Bradley, the two Lawsons and Joseph Fox were present. We all breathed the gaseous aziote of oxygen (N_2O). It took a surprising effect upon me abolishing completely, at first, all sensation; then I had the idea of being carried violently upwards in a dark cavern, with only a few glimmering lights. The company said my eyes were fixed, face purple, veins in the forehead very large, apopleptic stertor, etc. They were all much alarmed, but I suffered no pain, and in a short time came to myself.

January 9th, 1802.—Joseph Fox invited me to meet Dr. Jenner, Astley Cooper, etc., at his house, and go from thence to the Physical Society at Guy's, a paper on Cowpox being before the Society.

As a result of these and other meetings an interest in dental surgery was aroused. The result is told in the preface to the third edition of "The Lectures of Joseph Fox." During the time the author was engaged as a dresser of Mr. Cline, he found amongst the pupils of St. Thomas's and Guy's Hospitals a great desire to obtain particular information concerning the diseases of the teeth. Frequent conversation on these subjects, and descriptions of the modes of performing some operations, led to the delivery of a course of lectures on the Structure and Diseases of the Teeth. In this undertaking much assistance was rendered by Mr. (later Sir Astley) Cooper. The first course was given in the Spring of 1799, after which they were continued as one of the Spring courses of lectures delivered at Guy's Hospital, and finally gave origin to the present work. This proves conclusively that the first systematic and organised instruction in the world, given consecutively as part of the recognised courses and continued to this present lecture, took place at Guy's Hospital. These lectures were published in two parts, the first dealing more particularly with the formation and structure of the teeth appeared in 1803; the second part, describing the diseases of the teeth, gums and alveolar processes, appeared in 1806. Both parts together were republished in a second edition in 1814, and a third edition was printed in 1833. In the Gordon Museum is a series of dissections showing the development of the human jaws and teeth. These have been beautifully remounted in our own time by Colonel Dowsett, and he agrees with me that most of these are the preparations originally made by Joseph Fox, which as teaching specimens have been in continuous use for nearly 150 years. I show you another slide illustrating dislocation and now one showing Fox's method of treating irregularity of the teeth. You will see that this is the original method of that copied in our day by Edward Angle and used under his name all over the world to-day. You will see that all the essential features were described by Fox. There are the ribbon arch, the ligatures, the anchorage, the opening of the bite to allow of tooth movement. With our greater knowledge we should to-day open the mouth by an anterior bite plate to allow the cheek teeth to erupt, but in all essentials this widely used form of treatment was originated in this Hospital by Joseph Fox. The interest of Fox in children was extended to their education. With other young men he founded the British and Foreign Schools Society. When by imprudence this was brought to the verge of bankruptcy, he saved it by pledging his entire fortune of £4,000 on its behalf. A famous Guy's chaplain, F. D. Maurice, writing as a schoolboy from Bristol on September 12th, 1815, describes the effect of a speech which he heard Joseph Fox make for this cause in that city. Worn out with these professional and private exertions Fox died on April 10th, 1816, at the early age of forty. Queen Victoria's father, the Duke of Kent, wrote of him thus: "he felt the loss of that excellent man most deeply, whether he be considered as a private friend, or a public

philanthropist." The next year, on January 1st, 1817, another royalty, the Duke of Sussex, writing of the pleasure Fox would have experienced in knowing that the money for the schools was raised, says: "It is this hope which consoles us for the loss of a valuable friend: indeed, as an equal, one must consider the demise of a friend a personal loss, as nothing can replace him; and my friend Fox might, perhaps, have his equal, but his superior—most decidedly not." If any dental student here wishes to feel pride in his great profession, let him study the life of Joseph Fox.

Thomas Bell was the son of a doctor, and was born at Poole, in Dorsetshire, on October 11th, 1792. In 1813 he was entered as a pupil at Guy's and qualified as M.R.C.S. in 1815. Bell was always interested in comparative anatomy and began his career as a teacher by lecturing in this subject. Through Fox's lectures he became interested in dentistry; he joined Fox in private practice, and succeeded to his lectureship when he died. His lectures were published in book form in 1829, a second edition appearing in 1835. It is generally taught that the development of the tooth germs for the permanent teeth upon the lingual side of the tooth-band, was first described by Röse in the "Archives für Mikroscopische Anatomie" in 1891. It was however, clearly described both by Fox and by Bell, and I now show you one of the many human and comparative dissections made by Bell, which establishes this point. The question of circulation in the human teeth had been discussed by Hunter and others. Bell, by observations in the post-mortem room on people who had died by hanging, drowning, and with jaundice, demonstrated that there was in fact circulation of living fluids in the dentine. Bell considered the question of sensation in teeth, founding his observations upon the results of separating the teeth by filing with a thin flat file, as a treatment for dental caries. This is well described by a letter of Jane Austen's, dated from Henrietta Street, Cavendish Square, on Wednesday, September 15th, 1813:— "Going to Mr. Spence's was a sad business and cost us many tears. Lizzy is not finished yet. There have been no teeth taken out however, nor will be I believe, but he finds her's in a very bad state, and seems to think particularly ill of their durableness. They have all been cleaned, her's filed, and are to be filed again." Bell, commenting on treatment such as this, says that pain only occurs when the file is in contact with dentine, but never when it acts upon enamel only, from which he argues that there is no innervation of enamel, while that of dentine is highly developed. In later life Bell became Lecturer on Zoology in the University of London and published many books and papers dealing with this subject, although he continued to practise dentistry for all his working life. He published many scientific papers and books. In 1828 he was elected F.R.S. and was secretary of the Royal Society from 1848–53. As President of the Linnæan Society he was in the chair when the epoch-making papers of Charles Darwin and of Alfred Russell Wallace were read in 1858. Sir Richard Owen's great work on "Odontology" was dedicated to him. He ended his days at Gilbert White's house in Selborne and edited a famous edition of the "Natural History of Selborne" in 1877. In 1860 he was appointed as the first of the dental members of the Examining Board of the Royal College of Surgeons appointed to examine for the L.D.S.

J. A. S. Salter was the nephew of Thomas Bell and became a student at Guy's. He qualified as M.B. (Lond.), the first dental teacher here to hold a university degree. He joined his uncle in practice and, in 1862, succeeded him as Lecturer on Dental Surgery at Guy's. These lectures were published in book form in 1874. Salter was distinguished by his knowledge of pathology and especially for microscopic pathology. He took great interest in odontomes, describing the characteristics of true gemination in teeth of enamel nodules, and making and describing sections of rare specimens. He showed great interest in the problems of speech, teaching that the dentist shared in the artistic work of the sculptor and painter as well as in the scientific knowledge common to all branches of medicine and surgery. A notable part of his research was done in relation to reaction to injury in the dental pulp. He figures sections illustrating secondary calcification as the result of tooth wear in mastication, or by abrasion, or by slowly advancing caries. He demonstrated the relation of this reaction to the termination of the dentinal tubes and showed that secondary calcification took place in the tubes forming what are now known as dead tracts. In all these matters he was not always the first observer, but he demonstrated original specimens and showed their characteristics with accuracy. For example, he figures a section of internal absorption from the pulp and its replacement by calcified tissue, showing clearly the presence of regular Haversian systems in this tissue and demonstrating the fact that it is not an ordinary calcification resembling cementum.

Salter was followed by Henry Moon, who invented the Moon's probe and other instruments still in use.

There then came to Guy's a dynamic personality, Frederick Newland Pedley. He determined that there was scope for a separate School of Dental Surgery, to be attached to the Medical School at Guy's Hospital. He approached that truly great man, Sir Cooper Perry, who was at that time Dean of the Medical School. After investigation he induced the Governors to appoint a committee, presided over by Mr. Davies Colley, Senior, to consider the matter. They recommended that such a school should be established for a probationary period of five years, provided that neither the Hospital nor the Staff were involved in any financial responsibility. The first students entered this school early in 1889, and from that day to this it has never looked back.

And now, gentlemen, upon the completion of forty years' service at Guy's it is right that I should make some parting observations. First, I should like to acknowledge the unfailing assistance which has been given to me by the technicians of the Hospital. From Mr. Baker, Mr. Ireland, Mr. Roberts (of the Gordon Museum) and Mr. Dudley (of the Dental Research Laboratory) I have received more than help; it has been professional and scientific aid. Major Winston, Miss Delamere and the administrative staff of the Medical School Office make the pleasant and efficient life of Guy's possible for us all. Like all the visiting dental staff I have for many years lived obediently under the firm rule of Sister Broome and Sister Shields and their assistants, more patient rulers could not be found. To my colleagues upon the staff, young and old, I owe the most enduring of all links, the bond of friendship. My period at Guy's has seen the coming of a momentous change, in the establishment of the two dental professorships. In Professor Fenn and Professor Herbert we have found worthy occupants for these posts. The whole-time teacher is bound to exert a profound influence in the future upon our Hospital life. He is always there and in touch with everyone. It is easier for him to attend committees because he is on the spot, and he comes to such a meeting fresh and having had time to get the facts clearly before his mind. His colleague on the visiting staff has often had to rush his whole afternoon of private patients, often to go without tea and to struggle on a journey to get to Hospital. The result is, that he arrives tired and not in such good condition as the mentally alert and intellectually brilliant Professor. I am sure that for these reasons in recent years, in the Hospital as a whole, the Professors have been steadily gaining a principal share in the management of its affairs. In many respects this is a good thing. I believe that the Guy's staff spend far too high a proportion of their time in committee meetings discussing matters of which they are inadequately informed and upon which they cannot form good opinions. This time would be much better applied if we gave it to added preparation for teaching and to research. The time consumed upon committees amounts to many hours every year. If the staff as a whole were content to hold occasional meetings for the decision of general principles and then leave the details to be worked out by the whole time and administrative staff, who should be paid much more adequately than is done at the present time, the whole life and work of the Hospital would gain in efficiency. I do, however, wish to make an especial plea for the vital importance of my own class, the visiting dental surgeons. It must always be borne in mind that the primary purpose of a hospital is to treat patients and to train practitioners. None can do this so effectually as the visiting dental surgeon, who is himself a practitioner, immersed in those difficulties which only an actual practitioner can know and which his students will soon have to face. You will pardon me if I remind you that a visiting dental surgeon has to make constant sacrifice to carry on his hospital duty. A professor has done this once and for all; he has decided, for the sake of his teaching, to live on a fixed income and to receive a pension. The consultant, on the other hand, must deliberately sacrifice practice and annoy his patients by saying that he cannot see them every time he comes to hospital, which, including clinical work, lectures, and committees is at least three times a week. This represents a real and very great sacrifice, gladly but constantly made. I believe that the visiting dental staff should always be ultimately predominant in the life of the Hospital. The great thing is that all the staff alike should see each other's difficulties and the scope which exists for each. When our founder, Thomas Guy, wished to choose a motto for this institution he took from his shelves a book which still has a larger circulation throughout the world than any other book. From it he chose a saying of the greatest of all Masters: "I have showed you all things, how that so labouring ye ought to support the weak, and to remember the words of the Lord Jesus how he said, It is more blessed to give than to receive."

Exploration of the Region Between the Styloid Process and the Transverse Process of the First Cervical Vertebra

By PATRICK CLARKSON, M.B.(Lond.), F.R.C.S.

DURING the last two years it has been necessary from time to time to explore deliberately the region deep to the ascending ramus and condyle of the mandible. These explorations showed that access to this region and to the region immediately posterior was easier than had been thought, and encouraged the view that repair of the IX, X, XI and XII cranial nerves as they emerged from the base of the skull might be practicable. Six such nerve injuries have been explored. They are described here because the opportunity for such explorations is not common. In six further cases this region has been approached by the external route for removal of foreign bodies causing persistent discharge or interference with temporo-mandibular function. The report of this experience may be of value as the region is one which has had to be approached sometimes for more urgent indications—high division of the carotid, hæmorrhage of the internal maxillary, false and A–V aneurysm of the carotid, osteitis of the atlas and axis—when it has not been possible to display normal anatomy fully.

Five of the six nerve explorations were done for interruption of continuity of the hypoglossal; in four this was the only nerve injured. In two of these hypoglossal explorations the nerve was found to be involved in dense scarring for 1–2 cm. at about the level of C.1. On dissection of the scar the nerve was seen to be intact, and fasciculi seemed to traverse the part of the nerve that had been involved. These cases were therefore left without resection and graft. The lesion in the other two hypoglossals was found on exploration to be lower. In one, dense scar interrupted the nerve just distal to the origin of the descendens. It was impossible to approximate the gap of 1.5 cm. established after resection of the scar and a descendens-hypoglossal anastomosis was done. In the fourth case the nerve was found divided across the middle of the hyoglossus, and a gap of 1.4 cm. was approximated. This was the only case which showed evidence of recovery when last seen. In the remaining two cases the lesion were higher—flush with the base of the skull. In one, the Xth, the superior cervical ganglion and the internal carotid, were divided by a missile which passed through the antrum and had come to lie on the front of the atlanto-occipital membrane. At operation the lower ends of divided artery and nerve were identified, and the missile removed. The proximal end of the Xth was not found. The remaining case showed interruption of IX, X, XII and cervical sympathetic. The lower ends of the cranial nerve trunks were exposed and followed upwards to the jugular and hypoglossal foramina where they ended. The proximal ends being presumably within the skull were not found.

These explorations gave experience of the surgical anatomy of the region between the styloid process and the first cervical vertebra which may be summarised as follows: a curved incision running downwards from the mastoid to below and in front of the angle of the jaw with the head extended and rotated to the opposite side, gives good access to the region just in front of the transverse process of the first cervical vertebra and the lateral part of its arch. This is a roughly triangular region whose apex extends deeply. In the anterior wall lie, first, the styloid process and attached muscles, then the back of the internal carotid. The posterior wall is formed by the transverse process of C.1, the muscles which connect it to the base of the skull and the lateral part of the arch of that vertebra. The posterior belly of digastricus runs across the upper part of the base of this triangular region; the apex passes deeply into dense fibrous tissue towards the pharyngeal recess. The chief structure in the triangle is the jugular vein and bulb which here lies directly behind internal carotid. The cranial nerves are disposed around the jugular vein. The IX is often not difficult to find in relation to the stylopharyngeus in the anterior wall of this region; the Xth lies on the posterior wall behind the vein and medial to the XI, which is most easily found as it runs across the front of the transverse process of C.1. The XIIth nerve is best identified lower in the neck as it crosses the carotid bifurcation; it is followed up towards the anterior condylar foramen, which it reaches by passing in front of and then medial to the jugular vein

and foramen. The anterior condylar, jugular and stylo-mastoid foramina lie in a straight line across the base of the skull. Exposure of the anterior condylar foramen is facilitated by division of the jugular and lateral retraction of its cranial stump.

In this region the soft tissues are tough and fibrous, do not separate easily and contain many connecting branches between the cranial nerves and the sympathetic ganglion and cervical plexus. The dissection can be slow and tedious and is best done with diathermy hæmostasis. It is wise to isolate X, XI and XII nerves lower in the neck, to trace them upwards and to use them as guides to the other structures. If the history indicates that the internal carotid has also been divided—and any neck wound with a Horner's syndrome suggests this possibility—tapes should be placed around it at the bifurcation as the first stage of the operation.

The prognosis for recovery of IX, X and XII nerves after neurolysis at the base of the skull is not good, but it would probably be improved by resection of the scar and by the use of a nerve graft as a bridge. It has not been found possible to approximate gaps of 1 cm., high in the cervical course of these nerves, but a gap of about 1.4 cm. in the hypoglossal as it lay on the hyoglossus was successfully approximated. Mobilisation up to the level of C.1 and division of the occipital artery aided this. In nerves of this calibre even 004 silk is probably too thick; a plasma glue would be expected to give better results, both for grafts and approximations.

Obituary

Lieut.-Colonel GORDON TRAVERS BIRDWOOD, I.M.S. (retired).

LIEUT.-COL. GORDON TRAVERS BIRDWOOD died suddenly on April 14th, 1945, at the age of seventy-eight years. He was educated at Clifton College and Peterhouse, Cambridge. At this University he took the M.D. and M.A. degrees in 1896, and in the same year the Diploma of Public Health (London). After Cambridge he studied at Guy's Hospital and became a member of the Royal College of Surgeons.

In 1892 he took second place in the entrance to the Indian Medical Services. Between 1893 and 1897 he served with distinction in the 1st Abor expedition, the first Waziristan expedition, and the Tirrah campaign, and as medical and political officer to the Kurram escort. In 1897 he was appointed a civil surgeon in the United Provinces of India. In 1903 he was made Principal of Agra Medical School; he completely re-modelled the education of the school, introduced the English standard and enlarged the school buildings—seven years' hard work. His next appointment was of eight years, to the new professorial chair of Midwifery in 1912 at Lucknow Medical College. This department he organised upon the model of the Rotunda Hospital at Dublin and its teaching. He was made a Fellow of the Allahabad University and a member of the Child Welfare Committee of the Province. While serving in India he wrote two books —"Clinical Methods in Tropical Diseases" and "Practical Bazaar Medicines."

In 1920 he retired from the Indian Medical Service and bought a practice in Deal and Walmer. He was at once appointed surgeon to the newly-erected Deal and District War Memorial Hospital and until 1937 was its keen and active senior surgeon. He became President of the East Kent Association of Surgeons in 1934 and was Medical Officer of the Deal Child Welfare Centre from 1926 to 1936—a work to which he devoted his whole heart. He gave much attention to Deal Hospital and its development, inaugurating in 1935 an ophthalmic department.

Reviews

Essentials of Syphilology. By Rudolph H. Kampmeier, M.D., with chapters by Alvin E. Keller, M.D., and J. Cyril Peterson, M.D. Oxford, 1944. Blackwell Scientific Publications. Pp. 520. Eighty-seven Illustrations. *Price 25s.*

A LONG experience in charge of the syphilis clinic at the Vanderbilt University Hospital, coupled with a special interest and practice in post-graduate education in syphilis control, has prompted Dr. Kampmeier to provide a text-book on syphilis. In this undertaking the author holds some special objectives in the foreground. In brief, these are—(1) to present the concept of syphilis as a systemic disease of which

the manifestations may be manifold; (2) to promote thoroughness in history taking and physical examination by the physician; (3) to emphasise the necessity for laboratory confirmation of the clinical diagnosis; (4) to develop a critical evaluation of serological diagnosis; (5) to raise the level of suspicion of the part syphilis may play in chronic disease years after infection was acquired; and (6) to stimulate better antisyphilitic treatment.

The result of this undertaking is a good practical monograph on syphilis and syphilis control suitable for the undergraduate, the public health officer and the practitioner.

This volume differs from most text-books on syphilis in that it contains many case histories with their appropriate illustrations which are used to supplement the text descriptions of the various manifestations. This method has the considerable advantage of presenting the case as a whole and the patient as an individual. This individualisation is of much importance especially in the elderly cases of syphilis in which, as the author points out, the objective is not to cure but to attain resolution of the lesions and relief of the symptoms, and to prevent further damage; it is pointless to so manage the patient that the treatment is of greater danger than the disease.

For the routine treatment of the case of early syphilis the author advises neoarsphenamine and bismuth—presumably bismuth subsalicylate, but this is not clearly specified. Treatment is prolonged over a period of sixty-eight weeks and is comprised of four courses of neoarsphenamine and five of bismuth; these courses alternate, with the exception of the first in which the arsenical and bismuth are given concurrently, as they are in customary British schedules. The schedule of a modified form of abbreviated treatment is also set out in tabular form in which the treatmert with marpharsen and bismuth subsalicylate is condensed into a period of twenty-six weeks. The table in which the latter schedule of treatment is set out suffers much in clarity from its unfortunate division by the printer into portions on two separate pages; also, it is confusing to the reader to find one of the bismuth courses set out in the column dealing with the arsenical. This table would be improved by redrafting.

The sections dealing with neurosyphilis, with syphilis and pregnancy, and with syphilis of bone and joints are good; that on congential syphilis and its treatment is excellent.

The public health aspects of the disease are not neglected for the volume contains informative chapters on administrative measures, epidemiologic factors, and general educational measures in the prevention and control of syphilis.

The author provides a short list of useful references at the end of each chapter. The main index to this book could be extended with advantage. V. E. L.

Exercises in Human Physiology. By Sir THOMAS LEWIS. London: Macmillan & Co., *Price* 3*s.* 6*d.*

SIR THOMAS LEWIS has written this book to assist students in the transition from preclinical to clinical studies. The problems presented to the students in these two periods often appear different because of the difference in their conditions of presentation: the object of this book is to reduce this apparent divergence by the application of simple physiological reasoning throughout.

The majority of the exercises involve nothing more than simple and careful observation, apparatus being reduced to a minimum. They cover the ground associated with the author's work—*i.e.*, the circulation in the skin and superficial parts and cutaneous sensation. From simple observations the student's attention is directed to logical conclusions and applications. Apart from a short account of the use of calorimeters and plethysmographs for the measurement of bloodflow, all the exercises described are possible to any student who has patience and powers of careful observation. Nobody who faithfully cultivates such habits as are engendered by the exercises in this little book can fail to benefit thereby. W. R. S.

A Textbook of Histology for Medical Students. By EVELYN E. HEWER, D.Sc.(Lond.). London: Wm. Heinemann, Medical Books, Ltd. 1944. Third Edition. Pp. viii+364. With 344 figures in the text. *Price* 17*s.* 6*d. net.*

THERE seems a remarkable reluctance among writers of books which include accounts of cell division to revise them in the light of knowledge which has now been generally available for at least twenty years. It is unfortunate that in this

respect standard textbooks of histology such as those of Maximow (ed. Bloom), Bailey and others have not given the lead. However, this is no excuse for our own tardiness, and publishers should know of the importance of this matter and should insist upon their authors providing a modern account.

The text of this book is profusely illustrated by means of photomicrographs and numbers of diagrams and text-figures drawn by the author. Surely photomicrographs of histological material should either themselves be fully labelled or be accompanied by a carefully drawn and labelled outline (such as indeed is done in the section on the central nervous system at the end of the book). In the greater part of this book, however, the photomicrographs are not labelled in detail and the diagrams are of such a nature that they cannot but be severely criticised on the grounds that they do nothing to encourage the student in that all too rare virtue—accurate observation.

The text itself has a number of minor inaccuracies, but none of a serious nature, and since in other ways this book is reasonably adapted to the special needs of the medical student, it is a pity that its usefulness should be marred by the serious shortcomings mentioned. E. W. B.

The Blood Pressure and its Disorders including Angina Pectoris. By JOHN PLESCH, M.D. Baillière, Tindall & Cox. First Edition. 61 Illustrations. viii+146 Pp. *Price* 15*s.*

THIS book consists of three parts, dealing with the arterial blood pressure, the venous pressure and angina pectoris respectively. The first part contains a detailed description of the "tonoscillograph," an instrument providing a continuous record in ink of the oscillations in the blood pressure cuff at pressures from 0 to those exceeding the systolic pressure, and an account of the analysis of those blood-pressure charts. The clinical applications appear to be the author's personal views which often are presented without any attempt to substantiate or correlate them with accepted views. Some rather astonishing statements, taken at random, may be quoted to illustrate the author's approach. ". . . neither has the electrocardiograph taught us anything new which we did not know from the laborious analyses of Mackenzie and Wenckebach" (p. 14); the rise in the minimal pressure in essential hypertonia is considered as probably "due to a hormonal derangement contrary to that in Graves's disease"; in the latter "low blood sugar level" and "preference to warmth" are mentioned as characteristics, whereas "laziness and depression" are stated to be features of "hormonal hypertonia" (p. 56). A separate clinical entity called "capillaritis generalis" is discussed (p. 56–60), which appears partly to be related to Clifford Allbutt's hyperpiesia and partly to malignant hypertension and the statement is made: "In all such cases the case history shows that if there was an hereditary proclivity the disease was due to protracted suppuration, infection or chronic poisoning (metal)." Cyanosis is declared to be attributable "solely to the pressure and volume increases" (in veins and capilliaries) (p. 88). The intrathoracic pressure is stated to compress the ventricle (p. 80), the glomeruli "have little to do with the elimination of water" (p. 98). In regard to angina pectoris the old conception of an arterial cramp is revived, supposed to occur in an atonic artery. The last part of the book deals with the treatment of angina pectoris and some of the suggested measures—in particular, the dietetic ones—are as unorthodox as many other statements throughout the book. There is no bibliography and references in the text are confined to publications of the author. S.

Prevention and Treatment of Disease in Warm Climates. By Dr. T. GERALD GARRY, M.B.E., M.D. Medical Publications, Ltd. *Price* 8*s.* 6*d.*

THE author has dedicated this book to "The Armed Forces, Everywhere," and says in the preface that "it is intended for the troops now widely distributed in warm climates and for traders, travellers, and others who are frequently located in isolated districts."

Though no doubt a book, giving a clear account of the foundations of tropical hygiene suitable for the non-medical reader would be most valuable, the reviewer cannot recommend this partcular attempt.

The author seems to have lost sight of his original object and used the book as a vehicle for the expression of a number of muddled theories and personal prejudices on both medical and non-medical matters, many of the statements are inaccurate or misleading, and there are innumerable errors. M. S.

Fevers for Nurses. By GERALD BREEN, M.D., Ch.B., D.P.H., D.O.M.S. Second edition. E. & S. Livingstone, Ltd. *Price* 5*s.*

THIS is a useful little book giving the nurse a simple, clear-cut picture of the common infectious fevers. The diagrams are arresting and of the type nurses usually like. They are not overcrowded with detail and can be memorised easily. The chapter on immunity with its illustrations is particularly good. It appears to be the kind of book a nurse working in a general hospital may use. It is not sufficiently comprehensive for a nurse working in a hospital for infectious diseases. It is a pity that the whole of this small book is not taken up with infectious diseases instead of including sections on skin conditions, the giving of enemata and other procedures. Details of these are inadequate—*e.g.*, temperature of lotions omitted and, frequently, no quantity of the substance used is given. F. T.

An Introduction to Pharmacology and Therapeutics. By J. A. GUNN, M.A., M.D., D.Sc., F.R.C.P. Pp. 268. London: Oxford University Press. *Price* .

IN its seventh edition this ever popular little book has been thoroughly brought up to date and should do much to remedy the present shortage of books on pharmacology. It still remains, however, a short survey of the subject and it is not intended to replace the larger and more detailed books.

It will probably be of more use to those who are doing a clinical appointment than to those attending the lectures in pharmacology for the 2nd M.B. The reason for this is that, during the course of lectures for the 2nd M.B., an attempt is made to teach the principles of pharmacology and to give the student a knowledge of the experimental basis of the subject, leaving out of the lectures information on therapeutics and mention of several drugs which he will meet in his clinical training. This Dr. Gunn does not attempt, there being scanty reference to such things as methods of excretion and metabolism of drugs. No remarks are to be found on the experimental basis of pharmacology, and thus the book is unsuitable for 2nd M.B. students.

However, for those in the clinical period it makes excellent reading. It is short and the style is good. It covers a wide range of substances, providing information about their nature, mode of action and effects. Doses and some of the more important preparations of the drugs are also given. Its great virtue is that it is easily read and is free from the heaviness which is so noticeable in some of the larger books. It is the book to read when one has a few odd moments to spare with nothing to do and one can refer to it quickly and easily just before an examination, when such commonplaces as the dose of morphine seem somehow to have been forgotten.

It is well worth a journey to your bookseller. C. T.

Thomson's Outlines of Zoology. Revised by JAMES RITCHIE, M.A., D.Sc. London: Oxford University Press (Oxford Medical Publications). 1944. Pp. xii+1021. With 572 figures in the text. Ninth edition. *Price* 28*s. net.*

NO doctor or, for all that, no medical student who desires to keep up his interest in the animals of the world around him, both of to-day and yesterday, should be without a copy of the "Outlines" which has been in the forefront of general textbooks of zoology since first published in 1892.

The present edition—the first to appear since the death of its original author, Sir J. Arthur Thomson—has been carefully revised by Professor James Ritchie, and he is to be congratulated on bringing the book up to date and increasing its usefulness.

Nearly one hundred new figures have been added and more information about fossil forms has been included together with notes of recent findings. For example, that most interesting discovery of *Latimeria chalumæ* off the south-east coast of Africa has given us a living member of the Crossopterygii (a group of fishes formerly supposed to be extinct and which flourished 300,000,000 years ago). This is, perhaps, the most interesting "living fossil" yet discovered.

Although the book follows the "type" system—which has much to recommend it—frequent comparisons by tabulation are included which serve to crystallise the ideas to be taught and which otherwise are apt to be missed.

If any criticisms of this book are to be made then it is rather concerning matter that has been left out. Admittedly the book is already bulky and to add much more matter would be difficult, but it does seem to the present reviewer a pity that in some

way or other a fuller and more modern account of the embryological types could not have been included. There is no mention of spiral cleavage, and the accounts of the development of *Branchiostoma* (Amphioxus) and the vertebrate types lack any reference to organ-forming substances, organisers, or presumptive areas of development: all subjects of first-class importance to modern biological reasearch—including medicine.

Again, the nervous system has largely been treated anatomically with little concerning function and nothing about nerve-components. If treatment of these subjects is definitely not intended, and the bibliography (as stated) has had to have been sacrificed, surely the way to provide the key to further information would be by means of references in footnotes.

One further omission: the carotid ligament of the frog is not mentioned, although it is shown in one of the diagrams in the text.

However, let none of the foregoing remarks deter anyone from becoming the fortunate possessor of the "Outlines"; it is a book well worth having and this edition is a worthy heir of its predecessors. E. W. B.

Transurethral Prostatectomy. By REED M. NESBIT, M.D., F.A.C.S., Associate Professor of Surgery, University of Michigan Medical School, in charge of the Section of Urology, Department of Surgery. Published by Charles C. Thomas, Springfield, Illinois, U.S.A. *Price* 41*s*.

THERE has been a great demand in this country for a clear, full and concise monograph on transurethral prostatectomy. The young surgeon has found it difficult to extract the information he wants from the vast literature on the subject. Here he has it presented to him in an easily read form.

The first chapter gives an account of the blood supply of the prostate gland by Rubin H. Flocks, an understanding of this anatomy being an essential preliminary to any transurethral resection. The author then goes on to describe the handling of the resectoscope, selection of patients, anæsthesia, etc. He then describes the technique which he employs himself in doing the resection. Further chapters on after-treatment, and summing up results of operation follow.

The book is completed by an extensive bibliography and, perhaps, its most marked feature is the magnificent collection of diagrams by that well-known artist, Wm. P. Didusch. We can strongly commend this book to all and sundry who are interested in prostatic surgery. It shows what can be done and how to do it, and is, therefore, of interest to a wider field than those actually preparing to perform the operation themselves. W. D. D.

A Handbook of Gynæcology. By BETHEL SOLOMONS and EDWARD SOLOMONS. Published by Ballière, Tindall & Cox. *Price* 25*s*.

TO the student seeking advice as to the best textbook of gynæcology for use during his clinical period, this review will be of little assistance. The title of this book is "A Handbook of Gynæcology," and it is a very fair description. It is not meant to be a full textbook for the student, but rather a small reference-book for the practitioner—and as such will certainly be most useful. It is written chiefly in note form and consequently is a little difficult to follow without some previous knowledge of the subject.

The author has been Master of the Rotunda Hospital and is consultant to other hospitals in Ireland; it is to be expected, then, that many details of treatment will be at variance with the generally accepted teaching at this particular hospital. For instance, the suggested treatment for gonorrhœa in the female is "rest in bed; *if possible*, ... sulphathiazole, 1 gr., every four hours for twelve days. If there is no improvement in five to six days, a course of sulphapyridine in similar dosage should be started." Such a high dosage (72 gr.) of either sulphathiazole or sulphapyridine would seem to be undesirable, especially if it is not possible for the patient to rest in bed.

There are a fair number of printing errors in the text—in one case amounting to a whole paragraph—but that is a point of minor importance.

The book is attractively produced and contains a large number of helpful illustrations. It is undoubtedly a very useful handbook. G. W. G.

Aids to Orthopædic Surgery and Fractures. By I. E. ZIEVE. Published by Baillière, Tindall & Cox. Second edition. Pp. iv+270. *Price* 6*s*.

THIS new edition presents quite a comprehensive survey of the subject for the examination point of view only, but, in spite of that limitation, it gives the reader a fairly good idea of the subject which seems to be presented in orthodox fashion. J. P. M. B.

Aids to Clinical Pathology. By DAVID HALER, M.B., B.S. (Hons.), D.C.P. (Lond.). Baillière, Tindall & Cox. Pp. viii+358. Twenty-one illustrations. *Price* 6*s*.

THIS new addition to the "Aids" series is a combination of the old "Aids to Pathological Technique" with the "Aids to Practical Pathology." There are sections devoted to Post-Mortem Technique, Hæmatology, Cytology, Histology, Bacteriology, Serology, Parasitology and Biochemistry. The average student will find the sections devoted to Bacteriology and Hæmatology most valuable, and the Biochemistry section contains useful "normal" values. J. P. M. B.

Correspondence

A MESSAGE OF THANKS.

To the Editor of the GAZETTE.

SIR,—Will you allow me through your columns to express my grateful thanks to my former house surgeons and other friends at Guy's who contributed towards the very handsome silver salver and illuminated book which they gave me on the occasion of my retirement from the active staff. I am also exceedingly grateful to the very large number of old Guy's men who have written to me at this time.

Yours, etc.,

F. N. DOUBLEDAY.

48, Welbeck Street, W.1.

WOMEN STUDENTS AND MEDICAL SCHOOLS.

To the Editor of the GAZETTE.

SIR,—There has been some correspondence in your columns on the subject of the admission of women students to all medical schools. In my opinion, an important point—perhaps the most important point—has been overlooked.

The Government, in sharing the views expressed in the Goodenough Report, has accepted the principle that a proportion of women should be admitted to all medical schools. Now there is a definite shortage of medical practitioners and, under the most favourable circumstances, it would take many years before this deficiency could be made good, even in spite of the special efforts that will be made to increase the number of people qualifying yearly. I also think, and it will not be disputed, that a considerable proportion of women practitioners cease to practise after marriage; perhaps a proportion of this number continue to work part-time.

Thus the great drive necessary, on the part of existing medical schools and possible new ones to raise the annual number of students qualifying would largely be nullified.

In a word, insistence on a proportion of women being admitted to all the medical schools under the present conditions of limited teaching and accommodation—which state of affairs will last many years—would mean that most women students would displace a man whose services, as indicated above, would be more valuable.

Yours, etc.,

23, Oakeshott Avenue, N.6. J. W. LEWIS.

ENLARGING THE CLUBS' UNION.

To the Editor of the GAZETTE.

SIR,—We, being a number of students from different sections of the Hospital, desire to put before your readers the following ideas on the future of the Clubs' Union in the belief that they are shared *in toto* or in part by many others and therefore should be expressed publicly.

The Present Position.—The Clubs' Union provides good athletic facilities for medical and dental students. Social and cultural activities are few and ill organised, but this is not necessarily the fault of the Clubs' Union. Massage, electrical and radiography students have no hospital club or athletic facilities. Nurses have excellent premises, but few social or cultural activities and hardly any sports facilities.

The Future.—We feel that nothing less than a comprehensive Clubs' Union embracing *all students* at the Hospital would be worthy of the new Guy's. Before giving an outline of what we think the Union's scope must eventually be, we should like to give our reasons for advocating such a drastic change.

Reasons for Extension.

1. Already the Dramatic Society has been unable to affiliate to the Clubs' Union because it has women members. Other clubs or societies of similar mixed membership may well, and indeed should, be formed in the future.
2. In one case women students are already using Clubs' Union facilities—*i.e.*, squash. Mixed hockey has even appeared at H.O.P. !
3. A growing realisation of the need for a specialist to have a wide cultural background. The diverse selection of societies necessary to provide this can flourish better in a larger organisation where each society will be adequately supported.
4. The growing emphasis on the student status of the nurse and the need for adequate recreation for her. Many nurses here join such organisations as Overseas Club and English-speaking Union for their social facilities.
5. Lack of recreative facilities for Massage, Electrical and Radiography students.
6. Increased tendency for medical and dental education to be allied to the University with its complete service of social facilities. In London the latter is absent owing to decentralisation. The hospitals must provide their own.
7. The present plans for rebuilding, with every department of the Hospital staking its claim in the new building, requires that the Clubs' Union should look to the future on the broadest horizon. Already the Dean, in an interview with *Pulse*, has indicated that the authorities are considering the new college and catering requirements.
8. The recreative and social life of each section of the student community could be co-ordinated and improved by a comprehensive Clubs' Union, resulting in nothing but benefit to its constituent members.

Additional Pointers from War-time Experience.

1. Guy's men and women have "got together" in every kind of activity at the bases and there is no reason why it should stop. How much better if this could continue within the organised social structure of the post-war Guy's.
2. There are those who feel that the corporate spirit of the Hospital has been partly lost by the sector split-up. This scheme would help to weld a reunited hospital into a harmoniously working whole, and the Guy's family spirit would flourish anew.

The Extended Clubs' Union.—Some of us have evolved a tentative plan of organisation for this which destroys none of the existing bodies, but, rather, extends their usefulness. However, we do not wish to put forward details at this stage, but rather to emphasise that a Clubs' Union with a membership of nearly two thousand in order to perform adequate service deserves something akin in size and scope to the "Union" of the provincial university.

The component parts of the Union should be situated together in the new building and should consist of the following :—

1. Catering facilities—a restaurant and a cafeteria.
2. Common rooms—a men's, a women's, and a joint common room.
3. Hall—with well-equipped stage and projection facilities, suitable for dancing, dramatics music and large meetings.
4. Cloakroom accommodation.
5. Committee rooms.
6. Office and staff (possibly combined with *Gazette* office). **(?—Ed.)**
7. Possibly swimming-pool as in architect's plan.

The relationship of the College to the Union : We think the best scheme would be for the College to consist simply of residential rooms, etc., separate from, but in close proximity to, the Union which would provide the Residents with all the above facilities.

Possible Objections to Scheme.—Some may think that it involves too drastic a change to contemplate in war-time and that the effort necessary to it could not now be made. However, we submit that this principle of extension of the Clubs' Union to existing women students in the Hospital *must be accepted or rejected now*, for upon this principle the structure and shape of the social amenities of the new hospital is absolutely dependent. This does not mean that everything must immediately be changed completely. The process should be gradual (*vide infra*).

Some will object from prejudice or on traditional grounds. In 1891 the formation of the Clubs' Union gave recreational facilities here a new lease of life. We believe that to-day, by means of this same Clubs' Union, the social life of the hospital can be enlarged and enriched as befits the new stage in our history, soon we hope to be ushered in by the advent of the new buildings.

The Process of Change.—We are aware that the complete and detailed re-organisation could not be brought about all at once, nor do we think that desirable even if possible. We desire a gradual evolution, the first stage being the acceptance of the principle of admission of clubs of mixed or women membership to the Clubs' Union. Whether or not clubs accept women members is a matter for each individual club. Until these became many we suggest that women members might subscribe individually to the club concerned. Later on inclusive subscription rates could be negotiated. The financial implications of the enlarged membership are obvious. We feel that without difficulty the swimming, tennis and hockey clubs could run ladies' sides and add further laurels to our sporting record.

We would emphasise that this scheme, while increasing the facilities and possibilities of social exchange, in no way compels the man or woman student to have anything more to do with the opposite sex than at present. The liberty of the individual to retire or keep to his or her own sex is and must be preserved.

These are the ideas we have. We hope there will be reaction to them. We put them before the students and staff of Guy's convinced that herein lies a practical plan for the betterment of our life and that of our successors here. Do not read and forget. Air your views in writing if you approve or disapprove. Speak to your Clubs' Union or other representatives. Speak to the signatories below. Silence is said to mean consent !

R. SCHWARZ, Nurse.
G. M. BIRCHWOOD, Nurse.
B. E. MARSHALL, Radiographer.
S. M. CLARK, Radiographer.
P. M. PALIN, Massage.
M. J. GARRETT, Electrical.
B. D. GRANT, Medical.
J. R. DICKSON, Medical.
P. M. STEPHENS, Dental.
G. A. MORANT, Dental.

P.S.—This letter was written before Dr. Vertue's article in the last issue of the *Gazette* and is not advocating medical co-education at Guy's.

B. D. G.
G. A. M.

No anonymous contribution or letter will be published in the "Gazette" unless the Editor is provided with the name and address of the correspondent.

Sport

Hockey

GUY'S *v.* MIDDLESEX HOSPITAL.

Result: Guy's, 3; Middlesex Hospital, nil.

On March 24th, 1945, the Hospital XI showed signs of regaining some of that thrust and shooting powers which, last year, had enabled it to win both the inter-hospital knock-out competition and the six-a-sides. The game was played at H.O.P. against Middlesex Hospital, runners-up to Bart.'s in this year's inter-hospital cup.

Guy's pressed their opponents from the bully-off, and this sustained attack was rewarded after about fifteen minutes by a movement down the right wing which enabled Thompson to draw away by himself and score with a clean fine-angled shot from the edge of the circle.

Maintaining the initiative, Guy's scored again shortly afterwards, from the inside right position after a scrimmage in their opponents' circle.

From then until half-time the game was equally contested, and the Middlesex forwards several times carried the ball into the Hospital goal mouth.

The half-time score showed the Hospital leading by 2 goals to nil.

The second half found Guy's being hard pressed by the Middlesex forwards, and Walker, in goal, played a stalwart game as the last line of defence, throughout. Gradually, by good hard clearing on the part of the Hospital backs and halves, the game opened up and moved towards the Middlesex goal. Shortly before the final whistle the Hospital forwards attacked in unison and the ball came in from the inside right once more, to make the third and final goal.

Team.—(Goal) F. H. Walker; (backs) B. H. Prideaux, J. Swan; (halves) J. B. Harris, L. Carton-Kelly (secretary), K. W. Bolt; (forwards) G. Thompson, T. C. L. Parry, J. R. Burt (captain), J. P. M. Bensted, G. R. Wotton.

Blues

BLUES COMMITTEE.

At a recent meeting of the Blues Committee, the following awards were made:—

Rugby Football.—Full Blues: R. A. Dean, I. H. Hilliam. Half-Blues: P. S. Carton-Kelly, P. J. Dwyer, B. M. Gray, C. H. Kinder, A. G. McCallum.

Association Football.—Full Blues: I. A. H. Munro, R. Owen, L. J. L. Sykes. Half Blues:

I. L. Busbridge, R. A. C. Dove, W. A. Evans, H. R. C. Riches, A. E. Trist.

Hockey.—Full Blue: L. D. Carton-Kelly. Half Blues: J. P. M. Bensted, K. W. Bolt, A. J. Swann, H. W. Trusted.

Rowing Club.—Half Blues: J. D. Brett, J. A. Bulleid, T. H. S. Burns, D. Chapman, W. Van't Hoff, C. H. W. Williams.

Boxing Club.—Full Blue: C. H. Kinder. Half Blues: J. M. Pugh, S. F. A. Westgate.

Squash Club.—Half Blues: P. S. Carton-Kelly, R. Freeman.

A. BATTY-SHAW,
Hon. Sec., Blues Committee.

Association

INTER-HOSPITAL CUP.—SEMI-FINAL

Guy's, 3; St. Bartholomew's, 2.

(*Played at St. Mary's Ground, Teddington.*)

The game started disastrously for Guy's when Bart's scored twice in the first five minutes. Guy's gradually recovered from this set-back, but their defence was kept busy by a lively and confident forward line. D. G. Jones, having deserted the rugger field, played a steady game at right back and thwarted several dangerous attacks. M. J. L. Sykes reduced the lead with a goal from short range, but Guy's were unable to draw level before half-time. They were more on top in the second half and came near to scoring on several occasions. Finally, R. K. Foster made the scores equal with a remarkable goal. From 35 yards out he returned a goal kick, straight and hard, into the undefended net. Play swept from one goal to the other with desperate attacks by both sides. F. R. M. Young put in a long drive, which was parried by the Bart.'s goalkeeper. Murley, the Bart.'s centre half, played a great game and was continually breaking up attacks. The deciding goal came after the Guy's forwards had swept to their opponents' goal. The goalkeeper saved, but the wet ball slipped from his grasp to the feet of Foster, who made no mistake for his second goal. Bart.'s strove desperately to save the match, but the Guy's defence, with R. A. C. Dove playing with his accustomed skill, did not falter. Guy's will now meet St. Thomas's in the final.

Team.—I. L. Busbridge, R. A. C. Dove, D. G. Jones, F. R. M. Young, H. R. C. Riches, E. G. Murphy, R. Owen, R. K. Foster, A. E. Trist, M. J. L. Sykes, I. A. H. Munro.

INTER-HOSPITAL CUP.—FINAL.

Guy's, 3; St. Thomas's, 1.

(*Played at Chislehurst on April 21st, 1945*).

Guy's, winners of the cup, by beating St. Thomas's, again hold the trophy. It seemed certain soon after the kick-off that Guy's would have little difficulty in winning, as they were a team rather than a set of individuals. This was borne out in the tenth minute, when I. A. H. Munro scored from close range by a movement initiated by F. R. M. Young. Guy's maintained the offensive and were again rewarded by a goal scored from close in, by A. E. Trist in the thirty-second minute.

Half-time came with Guy's still pressing and St. Thomas's forwards not severely testing our defence.

After the interval St. Thomas's did their utmost to place themselves in a more favourable position and, after fifteen minutes' play, I. L. Busbridge was beaten by a hard shot. However, Guy's pressed hard and I. A. H. Munro scored his second goal with a crashing shot taken on the half-volley from a long throw from F. R. M. Young.

St. Thomas's were now a beaten side and on several further occasions Guy's nearly scored.

It is fitting that Bob Young, playing his last match as skipper, was the star of the game, having initiated all three goals. E. G. Murphy, so sound at full back, was also playing his last game for the side.

Team.—I. L. Busbridge, E. G. Murphy, R. A. C. Dove, E. M. Newton, H. R. C. Riches, F. R. M. Young, I. A. H. Munro, M. J. L. Sykes, A. E. Trist, R. K. Foster, R. Owen.

Guy's have finished the season well, winning their last six matches and also winning the Inter-Hospital Cup for the second year running.

RESULTS.

March 3rd.—*v.* St. Bart.'s (away). Won 7–3.
March 10th.—*v.* St. Mary's (home). Won 9–0.
March 17th.—*v.* R. Norwegian Para. Regt. (home). Won 4–3.
April 7th.—First Round Inter-Hospital Cup *v.* Charing Cross and Royal Dental Hospitals (away). Won 8–2.
April 14th.—Semi-Final *v.* St. Bart.'s (played on St. Mary's Ground, Teddington). Won 3–2.
April 21st.—Final *v.* St. Thomas's (played on Middlesex Hospital Ground, Chislehurst). Won 3–1.

M. J. L. SYKES,
Hon. Sec.

Athletics

The Hospital Athletic Club, which has been dormant for so long, is active again this season. It has recently won two matches against strong athletic schools—Bedford and Tonbridge. These encouraging results have been accomplished by the efforts of some ten enthusiasts, and it is hoped that the many potential athletes in the Hospital who have thus far held back will come forward in time for the inter-hospital competition to be held in June. R. H. N. Long is captaining the club and will be glad to hear from those wishing for a trial.

The Bedford match was a keen and close contest which was only decided by the last event, the relay, which Guy's won by a few yards, K. R. Heber hanging gallantly on to his lead over the last quarter. B. Hartley ran a fine race in the Mile and made up a great distance in the last lap to win in a fraction over 5 min. The results were:—

100 *yds.*—1, R. H. N. Long (Guy's); 2, I. B. Thomas (Guy's). 10.5 sec.

220 *yds.*—1, R. H. N. Long (Guy's); 2. Bedford. 23.8 sec.

440 *yds.*—1, I. A. H. Munro (Guy's); 2, Bedford. 55.4 sec.

880 *yds.*—1, Bedford; 2, I. A. H. Munro (Guy's). 2min. 14.5 sec.

Mile.—1, B. Hartley (Guy's); 2, Bedford. 5 min. 0.5 sec.

Long Jump.—1, Bedford; 2, Bedford. 18ft. 4½in.

High Jump.—1 (tie), R. H. N. Long (Guy's); K. R. Heber (Guy's). 4ft. 11in.

Weight.—1, Bedford; 2, J. Southgate (Guy's). 35ft. 8in.

Hurdles (120 *yds.*).—1, Bedford; 2, R. H. N. Long (Guy's). 17.0 sec.

Relay (220 *by* 440 *by* 220 *by* 440 *yds.*).—1, Guy's (I. B. Thomas, I. A. H. Munro, R. H. N. Long, K. R. Heber).

Result: Guy's, 52 pts.; Bedford, 37 pts.

The Tonbridge match was also in doubt until near the end. R. H. N. Long ran a wonderful quarter-mile to win by 10 yards in a very fast time. K. Ohlrich threw the discus with grace and skill, and he and J. Barker were much too good for their opponents. The results were:—

100 yds.—1, R. H. N. Long (Guy's); 2, I. B. Thomas (Guy's). 10.4 sec.

440 yds.—1, R. H. N. Long (Guy's); 2, I. A. H. Munro (Guy's). 51.0 sec.

Mile.—1, Tonbridge; 2, Tonbridge. 5 min. 4 sec.

Hurdles (120 *yds.*).—1, Tonbrid e; 2, B. G. B. Christie (Guy's). 17.1 sec.

Long Jump.—1, Tonbridge; 2, Tonbridge. 19ft. 1in.

High Jump.—1, Tonbridge; 2, K. R. Heber (Guy's). 5ft.

Weight.—1, B. G. B. Christie (Guy's); 2, Tonbridge. 35ft. 4in.

Discus.—1, K. Ohlrich (Guy's); 2, J. Barker (Guy's). 114ft. 8in.

Relay (880 *by* 220 *by* 440 *by* 220 *by* 880 *yds.*).—1, Guy's (K. R. Heber, I. B. Thomas, R. H. N. Long, S. Hartley, I. A. H. Munro).

Result: Guy's, 44 pts.; Tonbridge, 33 pts.

Hospital Information, etc.

Notice

The forty-fifth annual general meeting of Guy's Hospital Nurses' League will be held in the Physiological Theatre, Medical School, at 3 p.m., on Friday, May 4th, 1945.

The competitive exhibitions of photographs, paintings, sketches, etc., will be held as usual.

Pass List

SOCIETY OF APOTHECARIES OF LONDON.

PRIMARY EXAMINATIONS.

April, 1945.

Anatomy.

W. G. Burvill-Holmes

UNIVERSITY OF LONDON.

SECOND EXAMINATION FOR MEDICAL DEGREES.

March, 1945.

D. A. Ager	H. D. A. Hope
D. J. Anderson	K. M. S. Hume
K. Anderson	R. A. Keable-Elliott
D. S. G. M. Bailey	E. T. King
A. S. Bligh	R. A. Miller
A. W. Cook	H. R. C. Riches
A. A. Craigen	P. Ronchetti
D. C. Deuchar	P. A. Shave
C. J. Earl	B. J. Silkoff
R. L. Gothilf	K. Simpson
E. W. Graham	R. J. Vale
A. K. Hancock	A. W. R. Williamson

UNIVERSITY OF OXFORD.

B.M., B.Ch.

FINAL EXAMINATION.

April, 1945.

A. Batty Shaw J. D. L. Reinhold

Change of Address

Frank Cook, F.R.C.S. Telephone Nos.: Welbeck 1052 and (after 6 p.m.) Ealing 4169.

Paul C. J. Crisp (325480), Lieut., A.D. Corps, No. 22 A.D. Centre, Karachi, India Command.

D. A. Davies (72759), S/Ldr., R.A.F., No. 4 Hill Depot, R.A.F., S.E.A.A.F.

G. F. Gibberd, M.S., F.R.C.S., 20, Harley Street, W.1 (Tel.: Langham 4032).

E. B. Lowe (230703), Major, R.A.M.C., 9 (Br.) C.C.S., India Command.

Humphry Osmond, Surg.-Lieut., R.N., R.N. Hospital, Malta.

N. L. MacManus, Surg.-Lieut., R.N.V.R., H.M.S. *Ulysses*, c/o G.P.O., London.

W. N. Mann, Major, R.A.M.C., The Military Hospital, Edinburgh.

Mark Wilks, Surg.-Lieut., R.N.V.R., H.M.S. *Jervis*, c/o G.P.O., London.

The Services

AWARDS.

Military Cross.

Captain M. A. Freeman for gallant and distinguished service in Burma.

Mentioned in Dispatches.

The following have been mentioned in dispatches in recognition of gallant and distinguished services in Burma and on the Eastern front of India:—

Major H. G. N. Cooper, R.A.M.C.
Major (Temp.) D. G. Horan, I.M.S.

O.B.E. (Military).

In recognition of gallant and distinguished services in North-West Europe:—

Major (Temp. Lt.-Col.) C. E. Gallagher, R.A.M.C.
Major (Temp. Lt.-Col.) S. R. Trick, R.A.M.C.

Appointments

Dr. A. Churton Taylor has been appointed Honorary Anæsthetist to the Portsmouth and Southern Counties Eye and Ear Hospital.

Births

GOODHART.—On March 4th, 1945, at the Chelsea Hospital for Women, to Eileen (née Morgan), wife of John Goodhart, Surg.-Lieut. R.N.V.R.—a daughter (Anne Rosemary).

HALAMANDRES.—On March 31st, 1945, in Cape Town, to Barbara (née Rigby), wife of Costa Halamandres, Surg.-Lieut. Cmdr., R.N.V.R.—a daughter (Mary).

LEEMING.—On April 14th, 1945, at the Chelsea Hospital for Women, to Diana (née Palmer), wife of Donald Leeming, Surg.-Lieut.-Cmdr., R.N.V.R. (overseas)—a son.

Deaths

BIRDWOOD.—On April 14th, 1945, very suddenly, at Walmer, Kent, Gordon Travers Birdwood, M.A., M.D. (Cantab.), B.Ch., D.P.H., Lieut.-Col., I.M.S. (retired), aged seventy-eight.

CHAUNDY.—In March, 1945, in action in Western Europe, C. Anthony Chaundy, Capt., A.D. Corps, 6th Airborne Div., aged 29 years, 63, The Avenue, Kew Gardens.

SMITH.—On March 19th, 1945, Guy Bellingham Smith, F.R.C.S., aged eighty years, Yarrow, Felstead, Essex.

WETHERELL.—In April, 1945, by enemy action in Burma, Sydney Wetherell, Ft.-Lt., R.A.F.(V.R.), Weywood, Weybourne, Farnham, Surrey.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

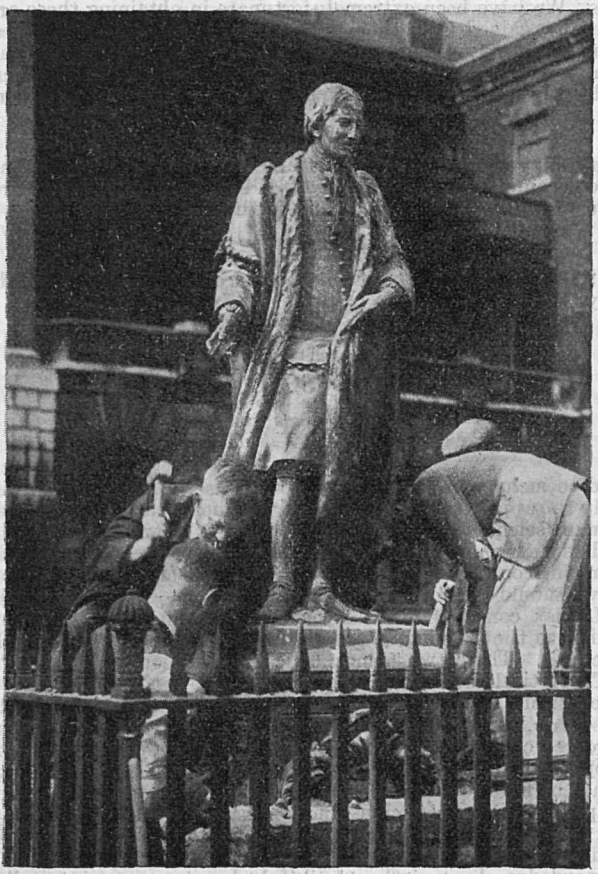
A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1482 *12th May, 1945* *Ninepence*

PASSIM

THIS fortnight has seen the long-awaited unveiling of Thomas Guy from his tomb of concrete, the first statue to be uncovered in London. This arising is, we hope, symbolical of the rising of a new Guy's from the dust of the old; now that peace is upon us, we anticipate that the plans for rebuilding will go on apace. Thomas Guy himself, though rather dusty after his five years' incarceration, appears otherwise none the worse for it and we must praise the foresight of those who thus enclosed him. Several photographs of the disinterrment were obtained, some depicting our worthy patron in rather undignified circumstances, and we are reproducing one of these in this issue.



By kind permission of Fox Photos Ltd.

This week has also been the occasion for a change in the offices of the *Gazette*. After the destruction by fire of the *Gazette* office in the left wing of the Front Quadrangle in 1941, the *Gazette* was accommodated in rooms in the right wing in Matron's House. Now, however, these quarters have been reclaimed for another use, and the *Gazette* has packed its bags again and moved to its new abode in St. Thomas' House

WE are indeed surprised that the letter on the Clubs' Union in the last issue of th *Gazette* has evoked no response, either in support of it or against it, through our columns. It seems remarkable that such a revolutionary—we cannot honestly say evolutionary—article should not either arouse a protest from the reactionaries or laudatory comments from those who wish to change the *status quo* in a twinkling. Beware of the ominous words of the authors of this letter—"Silence is said to mean consent." Some of the ideas in this letter are most praiseworthy and show a real grasp of the problems involved, but the idea of an "organised social structure for the post-war Guy's" fills us with horror. Far be it from us to damp the ardour of youth, but we feel that people are too apt to want to destroy an old system and establish a glorious new one without first fairly considering the merits of the old, and this does not only apply to the Guy's Hospital Clubs' Union. Finally, we would add that the idea of the *Gazette* office being thrown together with the office and staff of the Clubs' Union, presumably under the same management, fills us with something akin to awe.

IN this issue we are printing the first of three articles on "Clinical Discipline" by Professor Ryle. We have been extremely fortunate in obtaining these articles and we hope that the value gained from them will repay the trouble that Professor Ryle has taken in preparing them. We are also publishing an interesting clinical case in this issue; the practice of writing up cases for the *Gazette* has recently fallen into disuse, and we hope that this renewal of it will spur others on to give us their contributions.

ON Saturday, May 19th, 1945, we are to be honoured by a visit from Her Majesty the Queen, who is coming to Southwark to attend a service in the Cathedral; after this she has graciously consented to pay a visit to the Hospital.

WE would like to take this opportunity to welcome Mr. Frank Cook back to Guy's from the Army.

Clinical Discipline—(I)

BY JOHN A. RYLE.

I.

IF it be held to include the whole study of disease in man and man in disease and particularly the applications of such study, Medicine can hardly be called a science, although many sciences go to its making. Nor is it an art, although it has frequently been described as such and is often—and should always be—practised with something of the skill, imagination and sensitiveness which artists claim. If it must be defined—and I believe we should all think more clearly if it were—how then shall we name it? Sir Thomas Lewis* considered it, at least where education is concerned, as two things, according to the training, character and opportunity of those whose intimate concern it becomes. These two things he called "theoretical" and "vocational" medicine. Theoretical medicine and its rules of conduct he also very clearly defined and beautifully illustrated from his own experience under the alternative title of "clinical science."† It is directed towards the advancement of knowledge by careful and ordered clinical observation, by the collection and analysis of factual data and by the application of physiological methods at the bedside, including experiments (which must not be harmful) carried out on healthy volunteers and patients. Unless, however, the patient in these circumstances is handled with the same sympathy and frankness and attempts at an understanding of his physical and mental needs as are expected of the vocational physician, unless he is also made aware that he is helping to advance knowledge, I am rather doubtful—however experimentally desirable it

may seem—whether the clinical scientist should ever be entrusted wholly with his care. Indeed the ethics of all human experiment must soon be subjected to a judicial enquiry. The vocational physician's primary concern is not considered to be the advancement of knowledge (although as a teacher he may share and distribute it), but the diagnosis of disease and the care of the sick. But the vocational physician has advanced knowledge in the past, and ætiological studies and observational methods in his hands leading to the more detailed portraiture and analysis of diseases and symptoms still have contributions to make as important as those of refined experiment. Of him, however deep his human sympathies, I would say that if he is not actuated in some degree by the same critical sense which we expect in his theoretical colleague and which his earlier training sought to impart and his best clinical teachers endeavoured to nurture, he cannot become a really good physician. Unless he is as watchful of himself as his patients, unless he is thorough in his examinations and keeps faithful records and analyses his experience, unless he corrects his errors and prefers physiological treatments or watchful inaction to "trial and error" therapeutics, and so can train himself to avoid the old temptation to claim as *propter* what is only *post* in his recovered cases—he does not faithfully fulfil his mission, and may then deserve the imputation of failing to advance knowledge.

Briefly, it seems to me that our clinical scientist must remain a humanist while our vocational doctor must never forget the scientific directives of his professional training. In fact, Sir Thomas Lewis's two physicians should observe the same principles and be guided by the same ideas and ideals even if their problems differ and their functions and careers divide. What they must both cultivate is a "discipline," and clinical medicine, not as a science or an art, but as a discipline—with methods, principles and objectives of its own—is the definition which most appeals to me. It is a discipline slowly acquired and, in many ways, more difficult than the discipline of the laboratories. It must come, like other disciplines, to modify life and thought and action, seeking its own improvements, pruning its weaknesses, and acquiring strength thereby. Its scientific components must ultimately be welded by a philosophy which can only be fully developed in maturity. Its humanistic components, born of an understanding of brother man and sister woman, are just as necessary as its science. For without an appreciation of mind and personality and correct estimates of social circumstance, and without a knowledge of the contributions to health and sickness which environment —both material and personal—can make, none of our scientific assessments will be viewed in proper perspective and our applications of new knowledge may be faulty.

II.

What is the background of our clinical discipline in the years preceding qualification? Heredity, early upbringing and general education have clearly played their part and prepared the mould. The mould may accept its content readily or with difficulty. We may or may not be vocationally adapted. The preliminary sciences with anatomy and physiology give us necessary insight into the problems of biology and scientific method, but their courses are not at present so arranged as to tell us much about Man or Health or Disease, or man in health and disease, all of which are highly complicated phenomena and, for most of us, our life's concern. And so we are apt to enter the wards thinking in terms of local structure, departmental function and complex chemical activity, and our little store of knowledge does not always seem readily applicable to a sick man with a pain or an anxiety or both. As a rule we embark upon our clerkship or dressership with only a short and superficial introduction to new methods, methods which are mainly to do with case-taking and physical signs. The meaning of symptoms (in terms of physiology); the variability of the same disease in different subjects; the mortality and morbidity of diseases and their relative frequency in the population; the part which ignorance and fear can play in creating symptoms or modifying those due to physical change; the psychological, the social and the economic causes of ill-health—in fact, the whole of what may be called "ultimate" as distinct from "intimate" ætiology—these things we must generally, at present, discover very slowly for ourselves.

Pathology, bacteriology and biochemistry give us important materials with which to elaborate our composite pictures of disease, but they provide the materials only and not the inspiration, the technique or the skill. Radiography, cardiography, endoscopy and biopsy lend accuracy—although they can also mislead—to our mental images of structural damage, but they tell us less of functional derangement and often very little of the importance in the individual case of the changes observed.

Our closer contacts with the patient in the ward give us a view of him in a strange and unnatural atmosphere, for the sick man in hospital reacts differently from the sick man at home. We do not as a rule know what his home or his place of work are like—we may, as students, never have entered a slum dwelling or a factory—nor how his wages are got and expended, nor much of the difficulties which will confront him when he tries to carry out the advice given him on leaving hospital.

We hear bedside discussions on "a case" of this and that and tend to think of "diseases" and "cases" when what we need as urgently to understand is "patients" as fellow human beings. The selection of cases encountered in the wards is quite unrepresentative of the cases seen or encountered in a general or consulting practice or occurring in the population as a whole. Hospital admission requires either that the malady has reached a sufficiently advanced stage to compel it, or that diagnosis cannot be completed without special investigations, or that the disease is a rare and interesting one (as though all sickness were not interesting), or that the physician or surgeon in charge is himself a student of a particular condition or group of conditions. In general practice the majority of our surgical problems are minor ones, the majority of our medical problems are functional disorders. The very young and the aged are seen in larger proportion. Minor catarrhal and other infections and the exanthemata, with their seasonal variations, are plentiful. Many ill-defined aches and pains and anxieties confront us. Peptic ulcer is not the commonest disease and leukæmia and pernicious anæmia and disseminated sclerosis and other "interesting" maladies are very rare.

The artificial division of diseases into "medical" and "surgical" is bad for the student's mental discipline. It suggests that classification according to treatment is a reasonable one. Surgery is a therapeutic measure. Every "surgical" case has medical aspects. Many "medical" cases require surgical treatment. I have often thought that the ideal professorial unit should be "medico-chirurgical" and admit all cases of internal disease and all neurological cases to a common pool of beds in the first instance, so that each case could be diagnosed and treated on its merits after a consultation between colleagues. The bias due to admission to a particular ward or wing of a hospital would thereby be avoided.

III.

In the matter of humanistic discipline we must admit that on teaching rounds matters are sometimes discussed at the bedside which would make us very distressed or anxious if we were the patient, or very shocked if the patient were someone dear to us. Too rarely do teachers, pressed for time and absorbed in their discourse, pause after a demonstration to say a word to the patient in explanation or in comfort. And yet when we come to have patients of our own, careful examination, simple explanation, and, whenever possible, full or modified reassurance become (apart from operations and the specific remedies) the most important of our prescriptions.

But, it may be asked, what of all our modern methods of examination and treatment in hospital? Are not these scientific and the basis of our medicine? Do they not balance omissions in respect of intimate personal concern and management? Is not their use a discipline in itself? Science has certainly gone to their contrivance, but it does not always contribute to their use. Countless patients to-day are being subjected to the most elaborate X-ray examinations, test-meals, endoscopies and chemical and hæmatological studies and, at considerable but rarely considered expense, these tests are not infrequently repeated (often more than once) because a satisfactory diagnosis has not been achieved. These investigations are commonly conducted on the "passed to you please" plan and not as a true team enquiry. Detailed physical investigation with the aid of these methods have become the order of the day, while the thorough clinical overhaul, the friendly and simple psychological enquiry, and the co-operation of the relative, the ward-sister and the almoner as medical social worker is often what is really needed. No, the use of modern methods of investigation is not necessarily scientific. That judgement is most scientific which decides what investigations are most necessary or most likely to help in the individual case and, sometimes, how few and not how many should be employed, or which of them is best calculated to balance the other available evidence. That treatment is most scientific which is best suited to the patient's need and which takes into account both his immediate mental and physical requirements and, in the realm of after-care, his social, domestic and economic status and prospects.

IV.

Some of these are hard sayings. They call to account trends and developments in hospital teaching and practice which are to-day not universal, but too widely prevalent. They are based, not on hasty or hypercritical opinions, but on experience in many hospitals and many places over a number of years. The same criticisms of the same tendencies have been put to me by patients or their relatives and also by students or young graduates, who have been disturbed by things they have seen or heard in the wards, by the materialistic trend in medicine and this seeming forgetfulness of the patient as a person. Now I do not believe that these tendencies are due to an inherent loss of humane feeling but rather to the regimentations of institutional life, to habits of mind which overestimate the value of specific objective enquiry, and to pre-occupations with techniques. These pre-occupations compel curtailments of time and a loss of inclination for subjective enquiry, for the carefully planned or modified clinical approach, for the necessary co-operation between physician, colleague, patient, relative, nurse and almoner. Something has gone wrong with our hospital discipline. It has become departmentalised and mechanised.

For all forms of discipline some kind of drill—physical and mental—is necessary. It may seem a strange professional analogy, but I believe the commandos and para-troops of to-day, with their training in a great variety of activities and anticipations and in intelligent co-operative and individual action, and with their better officer-man relationship, are finer soldiers than the best parade-ground foot-guards of our earlier wars and that their superiority is due to other things besides their new weapons. We, on the other hand, have lost some of the old clinical discipline of our forbears, have not evolved a new one, and are all taken up with our new weapons, which have become more important to us than ideas and sensibilities, than principles ar judgements. We are depriving ourselves of the desire to think by constant reliance on sheaves of X-ray and laboratory reports. The uses of evidence and the evaluation of different kinds of evidence—first-hand and second-hand, historical, symptomatic, objective, instrumental, personal and social—do not sufficiently enter into our philosophy. In fact, this habit of investigation and of transfer of responsibility to our specialist colleagues of the clinic, the X-ray department and the laboratory (who can, as a rule, only give us a report upon parts of materials and not upon the patient and his whole complex of physical and mental ill-health) is robbing us of all pretence to a medical philosophy and a living discipline. Without a philosophy and a discipline judgement—the power to achieve balanced decisions on the whole disease, the whole patient and his whole need—is in danger of becoming a lost faculty.

* *Lancet*, 1934, I, 619, 651 and 685.

† "Clinical Science illustrated by Personal Experience." (Shaw & Sons), London, 1934.

A Case of Kummel's Disease with Secondary Pathologies

By R. O. BARBER, L.R.C.P., M.R.C.S., L.D.S.

"*And had suffered many things of many physicians and had spent all that she had, and was nothing bettered but rather grew worse.*"—(St. Mark, v, 26.)

SUCH, unfortunately, is often the lot of many of the chronic sick and ageing in the wards of our municipal and county hospitals. It is remarkable how often these patients are treated for a series of inconsequential exacerbations, which in time become more serious, whilst the real pathological course is not discovered or is disregarded and, by the time the correct diagnosis has been determined, the physical and mental condition of the patient permits not of the treatment of the real cause.

So many are the laboratory investigations available, so many are the new drugs appearing each week, so many are the ancillary methods of treatment, that too often but slight regard is paid to the individual and too much to the pathological condition. Having this in mind the following case is illustrative of the need for a reversion to clinical medicine based on observation and deduction, and prohibiting another misleading pathology from receiving all the attention, to no good effect, whilst the individual becomes weaker and weaker.

This case is also illustrative of (?) spondylitis post traumatica, which usually appears in young adult males, chiefly of the labouring classes. Kummel first described the condition in 1895, and Drummond gave details of a case in Guy's Hospital Reports (October, 1934).

The patient had been in the sector hospitals of two of the teaching hospitals; was evacuated from the second one when V 1 made its unswelcome appearance to a hospital in the North-East of England; and finally was transferred to the fourth hospital when she came under my care. I propose to give exactly and in full the registrar's case notes from the first hospital, adding the more outstanding developments of treatment and progress subsequently. The patient is now aged seventy-three.

HOSPITAL NO. 1.

Admitted 21.1.44; discharged 22.5.44.

Complaint.—Painful swellings of joints, especially hips, knees, shoulders, elbows, wrists and hands for two years.

History.—Pain is getting worse; has always been nervous. Frequency of micturition for several years, also pruritus vulvæ. Bowels not open regularly. Ten years ago (1934) *fell from second storey window and injured back of spine*; was in hospital for four months and had to walk with aid of stick afterwards; three children, all difficult births; several relatives had rheumatoid arthritis.

Examination.—Thin, flushed patient; vasomotor irritability; fixed expression. Intention tremor. Heart enlarged. Coarse lateral nystagmus. Swelling of metacarpophalangeal joints and both knees. All movements of limbs limited. *Fibrillation of glutei and quadriceps* after passive flexion of hips. Redness of labia and perinæum. Tonsils infected.

Progress.—Seen by gynæcologist *re* senile pruritus valvæ. Seen by E.N.T. specialist, who agreed tonsils are infected but that her age contra-indicated tonsillectomy. *Troubled a lot by frequency* which reacted temporarily to sulphathiozole, but which could not be cleared up satisfactorily. Diarrhœa for a few days.

Treatment.—Blood transfusion. General carbon arc, 4-cell Schnee—copper to feet. Short-wave diathermy to hands and knees. Thyroid gr. ½ daily. Oestroform Pot. Permang. two-way wash-out; Sobito, 1 c.c. every two weeks (to date two doses). Wax to hands. Throat paint.

Pathological Reports.—Throat swabs: On culture, Strep. Viridan; micro-catarrh. and Staph. Alb.

Catheter Specimen of Urine.—No sugar and no albumen. Heavy growth of *B. coli.* Hb on 11.3.44, 80 per cent. On 2.3.44 E.S.R., 36 mm. after one hour (Wintrobe). B. uric acid in January, 1944, 1.74 mgm. per 100 c.c.

Condition on Discharge.—ISQ mentally and physically. The main source of infection in her tonsils is still present and she still has frequency of micturition. The joint condition is no better.

Here, then, in addition to the many consultants she had visited before admittance to hospital, she was seen by many others and was well on the way to becoming a case of interest, but losing her individuality as a person.

HOSPITAL No. 2.

Admitted 22.5.44; discharged 7.8.44.

In the case-history the following additional points are observed:—

(*a*) First noticed *pain and muscular stiffness* in legs when on a walking holiday in 1940.

(*b*) Has been treated for "arthritis" in one form or another for past twenty-five years. Aortic sound accentuated. No murmurs. (B.P. 200/110). Very poor witness; liver palpable one and one-half inches below costal margin, smooth and not tender.

dema of both ankles and evidence of basal bronchitis.

Spine *kyphotic*; movements restricted; cannot walk or stand. Legs wasting; power reduced; jerks present and *brisk*; flexor plantar reflexes.

Distended colon; visible peristalsis; *ballooning* (P.R.); no mass palpable; fæces moist.

No Virchow glands; inguinal glands enlarged both sides. A diagnosis of:—(1) generalised arthritis—infective; (2) left-sided cardiac failure.

Hæmatology.—Erythrocytes, 4,720,000. Hæmoglobin, 78 per cent. Leucocytes, 9,000. Polymorphonuclear cells, 60 per cent.; lymphocytes, 32 per cent.; monocytes, 8 per cent.; eosinophils, 2 per cent. B.S.R.: 56 in one hour.

During her stay in this hospital the renal infection obtained prior interest; a good growth of B. coli was always present even after sulphadiazine.

25.5.44.—X-ray report. Cervical spine. A little osteo arthritis. Generalised osteoporosis of spine with wedging of upper dorsal vertebræ and *collapse of body* of D. 12. Appearance suggests senile osteomalacia.

8.8.44.—Got up for a short period. Stood with assistance. Resentful at her own progress.

Transferred August 6th, 1944, as infective arthritis.

HOSPITAL No. 3.

Admitted 7.8.44; discharged 2.3.45.

The following note is added on discharge:—"She had every kind of treatment and investigation for her condition before coming to us. She is at present having Mist. Pot. Citrate gr.LX 4 hourly.; Luminal, gr. 1.b.d.s. She lies all day long, not taking much interest in anything except her letters. She has to be fed; cannot write."

HOSPITAL No. 4.

Admitted on March 2nd, 1945, when I first saw her. To the above observations are to be added cutaneous hyperæsthesia in groin and outer side of thigh, paraplegia in flexion with increased tendon jerks, ankle clonus and extensor plantar reflexes—but no definite area of sensory loss was determined though there was diminution of sensitivity to all stimuli (possibly patient's mental condition contributed to this). On reading through the previous history it was decided not to disturb her more than necessary.

X-ray of the spine showed generalised osteo-arthritic changes with osteophytic formation, but no marked osteoporosis and collapse of wedge-shaped D.12.

A catheter specimen of urine (15.3.45) revealed:—Film (centrifuges): Excess of leucocytes and a few red blood cells seen. Abundant gram-negative bacilli and gram-positive cocci.

Culture (48 hours).—Profuse growth of enterococcus and B. coli.

18.3.45.—Had a severe headache, raised pulse, marked œdema of ankles, tender in midline and subumbilical region; and she was put on the seriously ill list. The exhibition of sulphathiazole had very bad effects and mandelix substituted with good result.

4.4.45.—Profuse growth of B. proteus; the enterococcus and B. coli have disappeared. Constipation appeared, even with enemata the results were poor. Pituitrin (1 c.c.) has an excellent effect.

In view of the above mixed history it would be pleasing to explain the whole on one pathology in strict accordance with Brock's ruling. Undoubtedly the patient has an arthritis, not an infective arthritis, but rather an osteoarthritis (menopause was at 40 and first joint symptoms at 48), so often accompanying senility especially in view of the fact that joints have never appeared inflamed and, after the lapse of over ten years, there is no deformity of any joints, only mild swelling, and movement is only slightly restricted.

One cannot help thinking that if fewer specialists had seen this patient less attention had been paid to the arthritic condition and more to the individual and the spinal condition with its far-reaching effects, the patient would be infinitely better in health. At the time of writing, her physical condition does not permit of any of the measures that could be adopted for the spinal condition which would relieve the renal and colonic upsets.

The arthritis first started, æt. 48, in 1920 in the knees. This could have been a climateric arthritis which predisposed the joints to further degenerative changes which with the declining years and infection of the renal tracts had an exacerabation, but it is really doubtful if primary admittance to hospital was necessitated by the minor

pathology (arthritis), but the major pathology (Kummel's Disease). During the stay in hospital for four months occasioned by the spondylitis, the result of the serious fall ten year, before (1934), it is extremely likely that the bladder was infected and remained so during the decade to 1944, when she was really admitted to hospital for investigation of her general condition, but the arthritic condition only was considered and the commencing spinal compression due to the spondylitis, which had been noted by X-ray six months after admittance to hospital (No. 2) was completely ignored. Now it is necessary to treat the secondary condition of chronic pyelitis and dyschezia and all hopes of curing the primary condition must be foregone ; a spinal jacket is the only method left for ameliorating the spinal condition, and one which might conceivably allow kidneys and colon to function more correctly with the aid of suitable drugs.

DIFFERENTIAL DIAGNOSIS OF THE SPINAL CONDITION.

Kyphosis in the aged is a very common finding ; with the advance of age degenerative changes due to continual strain on the components of the spine appear, due to the work of Schmorl it is possible to give accurate diagnosis, though not always treatment.

The changes fall into the following groups :—

1. True senile kyphosis is due to degeneration of the anterior portion of the discs, which, ultimately, may cause adjacent vertebræ to be joined at their anterior edge by spongy bone.

2. Spondylosis deformans is due to degeneration of the entire disc with osteophytic outgrowth on the anterior and lateral edges of the vertebræ, with or without kyphosis. Von Bechterew's disease affects the upper thoracic region, associated with root pains, sensory disturbance and some muscular wasting.

3. Senile osteoporosis is due to degeneration of the vertebral bodies, the discs being in an excellent state of preservation, bulging into the bodies. The osteoporosis is evenly distributed throughout the spine and also affects the pelvis, and gives rise to the appearance of " fish vertebræ " ; it is not due to osteomalacia, the serum calcium and serum phosphorus are normal and the serum phosphatase is not increased. Schmorl believed it was analogous to an atrophy of disuse. Albright *et al.* consider it is a primary atrophy of the osteoblastic system, resulting in a deficiency of bone marrow. The condition is a well-recognised post-menopausal change occurring from eight to fourteen years after the menopause.

4. Paget's disease is associated with changes in other bones and constitutional disorders.

5. Tuberculosis of spine is usually found in young persons and is too well known to need description.

6. Kummel's disease is a crumbling collapse of a vertebral body following an injury :—

(1) The injury may or may not cause a demonstrable lesion of the spine, and the patient may be confined to bed or be perfectly well and without symptoms.

(2) A latent period of varying duration then follows, which may be days or years.

(3) Return of symptoms, beginning with local pain and tenderness and with neurological symptoms of cord involvement later.

The original injury is usually to the anterior part of the vertebral body and interference with the nutrition of the bone causes a rarefying osteitis, the vertebra becomes wedge-shaped with clearly defined edges and the discs remain intact. In this case it is undoubtedly one of Kummel's disease with osteoporosis of the upper thoracic spine as a result of disuse atrophy.

SUMMARY.

A case has been discussed exhibiting in the main post-menopausal degenerative changes in the spine increased by the effect of trauma with concomitant renal tract infection and signs of cord involvement masked to a very large extent by climacteric arthritis. So little, at the present, is known of the biology of senescence and the effects of injury in the ageing that methods of diagnosis and treatment are by no means complete.

"Rope"

SETTLING into their armchairs the undergraduates ponder the great problems of life. To-night they toy with the fascinating subject of "perfect crime," and with their ideas Patrick Hamilton tries to build his play. He will follow an opinion to its logical conclusion—a difficult subject for a thriller.

In "Rope" the author, producer, players and stage-manager strive to put life into an abstract argument. It was much to their credit that they succeeded in the production by the Guy's Theatre Club. The action of the play took place after the commission of murder, so the play opened with a difficult scene, in which Mr. Eimar Filose neatly handled the revelation of what had gone before. The author made another difficulty in using only a single set, and we were reminded of the outside world by the ingenious use of a thunderstorm and of a gramophone, whose volume of sound was varied to suggest the opening and shutting of a door off stage. (What a pity the wireless persistently refused us further depth of setting !)

These limitations of time and space threw a burden upon the minor characters, without whom the most brilliant actors and dialogue could not have raised the plot above the level of a debate. For this reason "Rope" was a play well suited to amateurs, whose kenness was ample compensation for lack of training and experience. Mr. Tony Brewin as Sir Johnston Kentley, by his masterly confidence of action and speech, proved the heinousness of the murder of his son ; he won our hearts so that the reasoned exposition of the crime was superfluous. Miss Jean Thomas as Leila Arden and Mr. John Crossley (in the first performances Mr. John Hayward) as Kenneth Raglan showed us the value of a simple mind, and at the same time provided lighter moments which emphasised the predominating suspense. Miss Thomas and Mr. Crossley were untiring in spite of the uniform content of their lines.

It was a great feat of Mr. Crossley not to miss a cue, having had so little rehearsing. Mr. Michael Coplans as Sabot was interesting enough to make us wonder whether the "Colosseum" had proved beneath his dignity or beyond his comprehension.

The action of the play was developed in the words of Wyndham Brandon, Charles Granillo and Rupert Cadell. Mr. Michael Hall as Granillo was not too much carried away by the portrayal of developing drunkenness to give care to those words and gestures which roused Cadell's suspicions. The parts of Brandon and Cadell, played by Mr. Eimar Filose and Mr. Rodney Long, were similar to each other, since each had to show us his simple emotions underlying superficial intellectual talk. The skill of both actors was greater in this subtle suggestion than in the straightforward expression of their emotions, mostly in the last act. Mr. Long showed laudable economy of facial movement, whether his mood was playful, precious or sincere. Mr. Filose kept us attracted to the gruesome character which he played by his alternation of moments of terror with scrupulous attentions to his guests. At the crisis of the play we had the pleasure of watching Brandon resort to facile arguments, such as Cadell had used for his amusement but now no longer needed.

The moral of the play was that no crime could be diminished by facile argument and this only just succeeded in provicing amusement for two hours.

A great deal of credit was due to the competent production by Mr. Hall. To introduce a thriller with romantic valtzes was an amusing whim and to omit the "Danse Macabre" of Saint-Saens from the interval music showed admirable restraint.

We sincerely hope that the Guy's Theatre Club will maintain their high standard of enterprise and performance.

H. W. T.

British Dental Students' Association Annual Convention

(SOUTHERN REGIONAL COUNCIL.)

FOR the third year running the London Dental Hospitals gathered at Guy's Hospital on April 27th and 28th 1945, for the Annual Southern Convention, to which we were very pleased to welcome visitors from Bristol, Liverpool, Edinburgh, Glasgow, Leeds and Newcastle.

The Convention opened on the Friday afternoon in the Anatomical Theatre with Professor E. Sprawson in the chair. A most interesting lecture was given by Dr. Shuttleworth, Assistant Bacteriologist to Guy's Hospital, on "Penicillin and its Applications to Dentistry."

He gave a short account of the history of the discovery of penicillin, the experiments performed to discover its potentialities as a bactericidal agent, its properties and its methods of application. He then presented lists of penicillin sensitive organisms in the mouth and said the best method of using it here was in pastille form. Its success in the treatment of Vincent's infection and, to a lesser degree, paradontal disease were discussed. The usage of the drug in root canal therapy was described and its possible prophylactic use against dental caries, as certain strains of B. acid. Odont. were found to be sensitive to penicillin.

After tea, Mr. J. W. Mansie took the chair for a lecture by Mr. S. A. Leader on "The Scope and Limitations of Acrylics in Dentistry." Mr. Leader said that acrylic resin, because of its various excellent properties, was rapidly driving the other filling materials from use in the mouth. He also advised the use of acrylic resin dissolved in chloroform, plus a few drops of eugenol, as a lining for cavities cut for silicate phosphate restorations. With acrylic restorations one was able to produce any size, shape or colour. Acrylic teeth and crowns rarely fractured and attrition had little effect upon them.

Technical details of curing followed and he explained that the slower the curing and cooling, the less porosity was caused. He also demonstrated the immense value of high tensile glass fibres for strengthening acrylic products, and the fact that radio opaque acrylic resins could now be made.

After an interesting discussion and much amusement with an impact testing machine the Convention dispersed, our guests from the provinces going to the now peaceful homes of the dental students in Southern England.

On Saturday morning, with Professor W. E. Herbert in the chair, the students reassembled to hear Mr. G. Bankoff read a well-illustrated paper on "Plastic Facial Restorations." With the aid of many slides and photographs he showed many perfect facial restorations necessitated by congenital defects, disease and trauma. The methods of obtaining these results were gone into in great detail and the necessity for collaboration between plastic surgeon and dental surgeon emphasised.

After lunch we were pleased to welcome back Mr. Doubleday, who took the chair for the afternoon. Mr. D. C. Bartley, the Legal Assessor to the Dental Board of the United Kingdom, gave a very interesting lecture on the relationships of the dental surgeon to the law, both in the past and the present. He outlined the various acts since 1878, which gradually brought more and more protection for the public from the dentist and *vice versa*, and described how the various loopholes in the law and been closed up in the last sixty years. He also told the students what the functions of the Dental Board were, raised the vexed question of dental repair shops, and said what constituted unprofessional conduct in the eyes of the Dental Board.

This was followed by tea in the College, and afterwards the students were shown two films by Dr. J. W. Walker, of Bayer Products, Ltd. The first was on the use of evipan sodium for dental operations; and the second, a colour film, of a sub-total thyroidectomy.

The Convention was concluded by a dance at the Paviours Arms, Westminster, where, despite the weather, a certain shortage of some liquors and a missing M.C., a fair-sized gathering danced, drank and ate until 11 p.m.

The Southern Regional Council of the B.D.S.A. would like to thank those students of the London Dental Schools, who provided accommodation for our provincial visitors.

The Convention showed that, despite wartime difficulties, the British Dental Students' Association is not dormant, but a live and vigorous organisation, which, with peace in the offing, will, we hope, flourish even more.

G. R. M. M.
P. G. S.

Sport

Rugby

RESUME OF SEASON 1944–45.

(101ST SEASON.)

We are indebted to Mr. Roy Holloway for his statistical report on the performances of the rugger club during the past season. It has been a disastrous season in every way, and the percentage is the lowest on record.

Of the twenty-one matches played, three were won, two drawn, and sixteen lost. Points: For, 94; against, 270.

The team never recovered from a number of injuries received in the opening matches, and the three-quarters thereafter were constantly changing. The only regular performer was N. K. Macrae-Gibson. Several junior players were tried, but, one after the other, they were either injured, or failed to make the grade, and dropped out. The weakness of the backs definitely contributed wholly to our poor performances. This is further demonstrated by the names of the try scorers. W. Selley on the left wing obtained four, followed by three forwards—A. G. MacCallum, P. S. Carton-Kelly and R. A. Dean—with two each. In all matches the backs scored only ten tries of the eighteen scored.

Another deplorable factor was the poor place-kicking. Only one try was converted, but ten penalty goals were kicked. All through the season the forwards were brilliant, frequently giving weight away, but holding their own by solid scrummaging. It was in the loose, where their superior speed told most, and which made them one of the best packs in London, but it was most disheartening, having got into an attacking position, to find the backs dropping passes and out of position.

There was a pronounced improvement towards the end of the season, when the back division became settled. B. M. Gray improved a lot at full-back, and with the return of P. J. Dwyer and D. G. Jones in the centre, and N. K. Macrae-Gibson on the right wing, and W. Selley or J. M. Pugh on the left, the line really moved well. Owing to an early injury to E. W. Graham, the stand-off half position was never adequately filled, until the arrival of G. P. Billingham, who soon demonstrated a sound knowledge of the game. One always sympathised with R. D. Willcock, one of the pluckiest scrum halves one would ever wish to meet, his good work being nullified by an ever-changing partner, and numerous errors by the backs.

The forwards practically selected themselves, A. Batty Shaw, C. H. Kinder and R. A. Dean forming the front row; A. G. McCallum and I. H. Hilliam the second; R. G. L. Brittain, P. S. Carton-Kelly, C. P. Mills or S. M. Hilton, the back. C. Vidot's services were invaluable, but he was unable to play regularly. Others to render good service were D. Le Clus at full-back, and K. B. Pritchard at stand-off.

R. G. L. Brittain carried out his duties as captain with commendable skill, in addition to playing at the top of his form. Unfortunately, after qualifying, he was posted to a base hospital and resigned the captaincy, I. H. Hilliam being elected to carry on, and to continue for next season.

A. Batty Shaw had worked hard and efficiently as hon. secretary for two years, but examinations compelled him to resign late in the season, and R. D. Willcock took over. Batty Shaw's enthusiasm was tremendous, his main object being to do everything in the interests of Guy's rugger.

Three performances stand out from all others, and these at the close of the season. The powerful Coventry XV were given a very close game, although we were beaten 14–3, but the excellent win over St. Mary's (10–0) surpassed everything, bringing congratulations from several parts of the country, and losing to Wasps by 3–0 was by no means a bad performance.

On the whole, enthusiasm for rugger at the Hospital was at a low ebb, and the junior XVs always had difficulty in fielding representative sides, due to last-minute scratchings. Many players thought little of letting their side, or the Hospital, down, and there were others, although fit, needed too much persuasion to play.

When the season opened fixtures were arranged for three XVs and, after a couple of weeks, a fourth was fielded, but after Christmas it was an effort to get two XVs out, which definitely interfered with the standard of play.

This sort of thing has not been uncommon at Guy's, and, curiously, such behaviour has usually come at a time when the 1st XV are passing through a critical period.

The new captain, I. H. Hilliam, makes a special appeal to all rugger players to get ready for next season. It is recalled that the years following the war of 1914–18 were some of the brightest in our long history, and as next season will see the return of some of the big clubs, only first-class rugger and fitness will keep Guy's on top. The competition will be great, and there is the Inter-Hospitals Cup to be regained.

G. A. R. W.

MIDDLESEX COUNTY SEVEN-A-SIDE COMPETITION.

It has become customary during war-time for Guy's to enter two VIIs in this competition. Our first VII had exemption to the fourth round, but our second VII played through three rounds at Colindale on April 14th, and earned for themselves the coveted honour of appearing at Richmond on Finals day.

The second VII beat Kodak 11–8; Rosslyn Park Colts, 3–0; and a composite VII, labelled "Shamleeks," 3–0. Our tries were scored by W. Selley (4), B. M. Gray (1), K. B. Pritchard converting one.

The second VII put up a courageous performance against St. Mary's 1st VII on Finals day, and, although beaten 16–0, had a fair share of play until Pritchard retired through injury. At this stage, Mary's were leading by a try to nil and were compelled to exercise all their skill.

Team.—B. M. Gray, W. Selley, K. B. Pritchard, P. H. Bright, R. A. Dean (captain), J. H. Keiling, A. G. MacCallum.

The first VII met R.A.F. Jurly, who were runners-up last season, and the defeat of Guy's by a goal and a try to a goal was due to Jurly's greater knowledge of the seven's game. Guy's had ample opportunity to win, but did not possess sufficient speed, or technique, to turn defence into attack.

R.A.F. scored a try in the first half against a strong wind from a forward rush, but Guy's went ahead with an excellent try by N. K. Macrae-Gibson, following some accurate passing by J. W. Dwyer and D. G. Jones, which the latter converted with a good kick.

P. S. Carton-Kelly saved a certain try by

kicking the ball dead, following a bad kick by one of our backs, but close on time Jurly got the ball from a loose scrum in midfield and had no difficulty in grounding the ball under the posts for an easy conversion.

Team.—N. K. Macrae-Gibson, D. G. Jones, P. J. Dwyer, R. D. Willcock (captain), C. Vidot, C. H. Kinder, P. S. Carton-Kelly.

INTER-HOSPITAL SEVEN-A-SIDE COMPETITION.

(At the Athletic Ground, Richmond, on Saturday, April 7th, 1945.

Once again Guy's were beaten by Middlesex, this time in the first round. Middlesex were by far the better tacticians, quick to seize openings, and more speedy in every way. They led at the interval with a try by McIver from his own " 25," following a kick ahead by Dwyer, which resulted in a loose scrum. Seidelin went over soon after the restart and MacIver converted, but Willcock reduced the lead with a try which raised faint hopes. Thomson, however, intercepted a pass and scored easily, leaving Middlesex winners by 1 goal 2 tries (11 points) to 1 try (3 points).

Hospital Information, etc.

Papers by Guy's Men

Witts, L. J., and Others. Treatment of infective hepatitis with methionine. *Brit. Med. J.*, 1945, i, 401.

Burn, J. H., and Others. Antidiuretic action of nicotine. *Ibid.*, 403.

Southwell, Neville. Treatment of Cardiac Asthma. *Med. Pr. & Circ.*, 1945, 108, 212.

Conybeare, E. T. Rheumatism: an unsolved problem. *Pharm. J.*, 1945, 154, 172.

Fido, C. A. Penicillin: its uses in cases of Vincent's and other oral infections. *Brit. Dent. J.*, 1945, 78, 193.

Ford, W. G. C. A central incisor with normal X-ray and visual appearances causing deceptive symptoms. *Ibid.*, 204.

Selly-Brown, H. Removal of a broken hypodermic needle. *Ibid.*, 211.

Rowlett, A. E. Goodwill visit to America. *Ibid*, 219.

Broster, L. R. The thyroid in relation to other endocrine glands. *Post-Grad. Med. J.*, 1945, **21**, 52.

Knott, F. A., and Clark, W. H. Absorption of aerosol penicillin *via* the lungs. *Lancet*, 1945, i, 468.

Barnes, J. M. Lower Third Molar lost in the Soft Tissues. *Brit. Dent. J.*, 1945, **78**, 243.

Carpenter, E. Brodie. The relationship between Food, Soil, and Dental Caries. *Med. Pr.*, 1945, **213**, 268.

Drummond, R., and Others. Potent anti-Rh. Agglutinins, developed in an Rh.-negativ after multiple transfusions of Rh.-positive blood. *Brit. Med. J.*, 1945, i, 584.

Whitwell, G. P. B. Dermatitis from cutting oils. *Lancet*, 1945, i, 528.

Ogilvie, W. H. Some applications of the surgical lessons of war to civilian practice. *Brit. Med. J.*, 1945, i, 619.

Witts, L. J., and Another. Transmission of infection during withdrawal of blood. *Ibid.* 625.

The Services

CASUALTIES.

Captain C. Anthony Chaundy, A.D. Corps, 6th Airborne Division, killed on active service in W. Europe.

Ft.-Lieut. Sydney Wetherell, R.A.F.V.R., killed by enemy action in Burma.

AWARDS.

O.B.E. (Military Division).

Lieut.-Colonel (Temp.) A. C. Cox, R.A.M.C. in recognition of gallant and distinguished services in Italy.

M.C.

In recognition of gallant and distinguished services in Burma:—

Captain O. P. Llewellyn, R.A.M.C.
Captain T. C. Thorne, R.A.M.C.

Mentioned in Dispatches.

Captain J. R. D. Williams, R.A.M.C.

Change of Address

Frank E. Barlow (266085), Captain, A.D. Corps, O i/c No. 2 Mobile Dental Centre, c/o 327 Army Dental Centre, A.P.O.

Miss N. L. Beckett, P/329372 Q.A.I.M.N.S. (R.), Serial R.F.R.L.Q., India Command.

D. G. Dixon (244460), Captain, R.A.M.C., H.Q.C.R.A.S.C., 30th Transport Column, B.L.A.

J. L. Sarginson, Captain, A.D. Corps, 4 British Field Ambulance, S.E. Asia.

D. R. S. Saunders, Surg.-Lieut., R.N.V.R., H.M.S. *Rocksand*, c/o G.P.O., London.

Awards

The following awards have been made:—

Michael Harris Prize in Anatomy.—D. C. Deuchar.

Wooldridge Memorial Prize in Physiology.—D. C. Deuchar and C. J. Earl (bracketed equal).

Junior Proficiency Prizes.—D. C. Deuchar and C. J. Earl (bracketed equal).

Marriages

BAILY—LONGMIRE.—On April 30th, 1945, at St. Paul's, Knightsbridge, Ralph Arthur John Baily, Surg.-Lieut., R.N.V.R., to Betty Longmire.

Deaths

HOLMAN.—On May 2nd, 1945, Frank Kay Holman, M.D., in his eighty-second year, at The Old Orchard, Horsell, Woking, Surrey, formerly of Avenue Road, N.W.8.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1483 *26th May, 1945* *Ninepence*

PASSIM

A FORTNIGHTLY journal must inevitably be behind the times on occasion, so the following brief description of how Guy's celebrated victory will be news to but a portion of our readers; to the rest it can serve only as a reminder of what has gone before.

While we may not call the visit to the Hospital of Her Majesty the Queen and Princess Elizabeth an integral part of our own victory celebrations, its occurrence while the rejoicings were still fresh in our memory was a happy coincidence. Though the Blue Ensign of His Majesty's Royal Naval Reserve had for some days previously, been flying from the top of the old Surgical Block as the earliest visible harbinger of victory, Monday evening's pronouncement was first brought to us by the magnificent concerted din of ships' sirens starting up in unison from the Pool and the docks. That night and the next, old Guy stood glinting and glowing in the leaping flames and red glare of bonfires, sharing them with the surrounding throng—Guy's and Borough folk alike. Sorties were made to the West End; while, for those who preferred Southwark, there was dancing in the streets and dancing in the bar-parlours to the merry tapping of tankards on bars and counters. We hope that as many as possible old Guy's men and women enjoyed themselves equally well.

Such of the festivities as are described above were to be expected, but few forsaw the sudden invasion of the Hospital's precincts by several hundred King's College students on the morning of VE+two. Realising that unless something was soon done, Guy's, which had survived five and a half years of war, might become the victim of but a single morning's peace; no time was lost in hosing the intruders off the premises. It may be, that there are some who would criticise the spending of most of one morning scrapping over the possession of a red lion and of the same afternoon in disposing of this bone of contention; and that such criticism is levelled, not so much at the destructive nature of the affray—for little more than superficial untidiness was wrought—as at the flaunting by medical students of their reserved occupations before the eyes of London. Fortunately the public do not, in fact, appear to have taken this view and, to us, it seems that the incident not only savours little of vice, but might even solidify to some small degree the Hospital's student society, rift by the rustications of war-time.

LONDON to Belsen is a bigger step than a mere few hundred or so flying miles; and while we have seen many brief allusions to "the hundred London medical students who are doing relief work at Belsen in the daily Press, it is interesting to obtain first-hand information of this other world from one of the Guy's party. We hope to be able to publish further letters from this source.

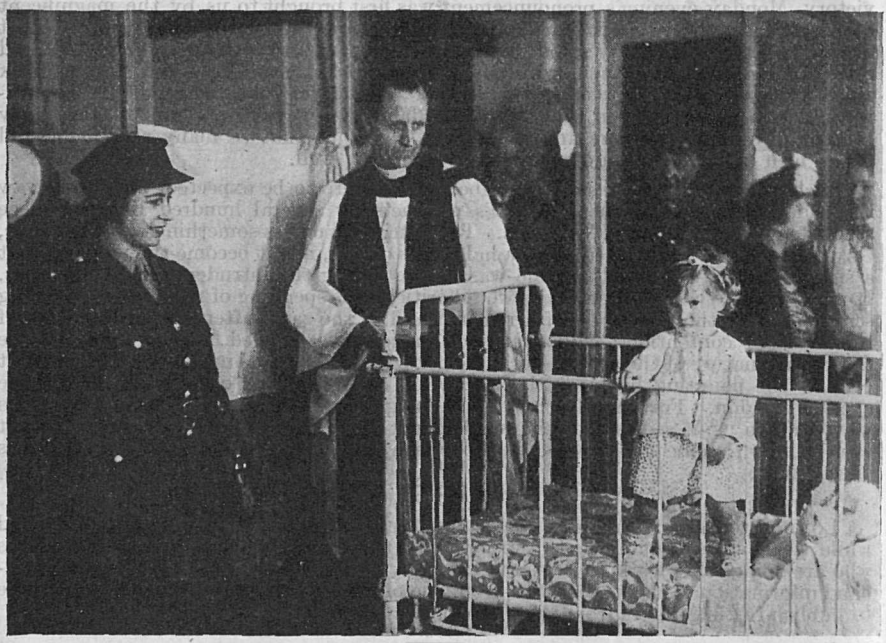
WE are pleased to be able to welcome Mr. Ogilvie back to Guy's from the Forces.

MANY readers have expressed from afar, curiosity concerning the amount of air-raid damage that the Hospital has incurred during the War. Now this information may be given and it will shortly be ready for publication.

The Royal Visit

HER MAJESTY THE QUEEN and Her Royal Highness Princess Elizabeth visited the Hospital on Saturday, May 19th, 1945, after attending a service in commemoration of William Shakespeare at Southwark Cathedral. The Royal Party arrived at the Cathedral at three o'clock and were greeted by the populace of the Borough, who had turned out in full strength to welcome them. The service itself lasted about an hour and was interspersed with some of the better known Shakesperian speeches and by some of his songs, sung by children from seven schools in Southwark.

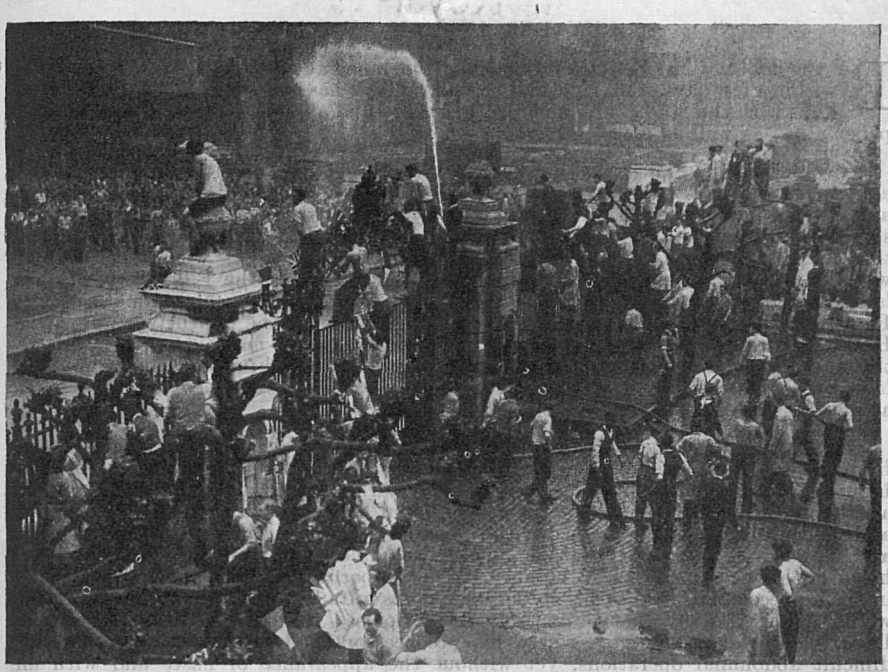
After the service, the Queen made a tour of the Borough and eventually arrived at the Front Gates of the Hospital, where she was received by the President, Viscount Nuffield, and the Treasurer, Mr. John E. Humphery. The Royal Party, together with the Mayor and Mayoress of Southwark and the representatives of the Hospital, preceded by the Hospital Mace Bearer, Mr. Southcombe, then made their way to the Nurses' Home through a guard of honour of Sisters, Nurses, Physiotherapists and Radiographers. After taking tea, the Queen and Princess Elizabeth visited Hunt's House, where the Queen talked to the patients in Addison Ward, and the Princess, accompanied by the High Commissioner of Australia, went up to Diplock Ward and presented a cot on behalf of the Girl Guides of South Australia.

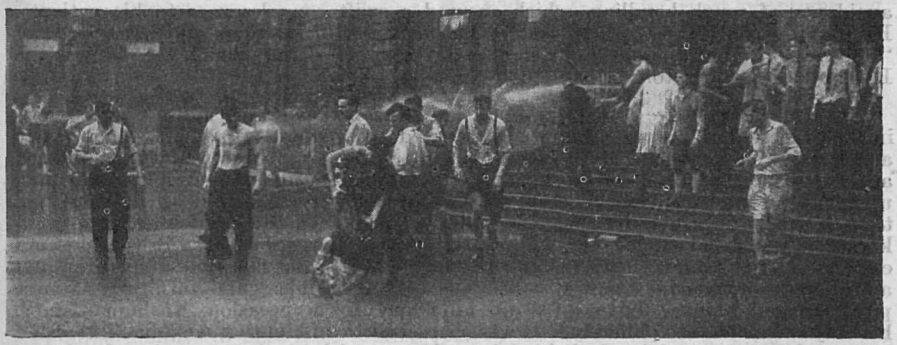


"Fox Photos Ltd."

The above photograph pictures H.R.H. Princess Elizabeth at the presentation ceremony, together with the Provost of Southwark who afterwards dedicated the Cot. After this a bouquet was presented to Her Royal Highness, who talked with some of the patients.

Guy's v. King's





"*Fox Photos Ltd.*"

The above photographs illustrate the invasion of Guy's by King's College on the morning of Thursday, May 11th, 1945. The aggression was prompted by Guy's seizure of King's trophy, "Reggie," the red lion, earlier in the week. The dental and medical schools bore the chief brunt of the visitors' search-parties before they were finally expelled through the Colonnade and Front Gates into St. Thomas' Street. In the course of the ejection from the Medical School, the bust of Richard Bright was, unfortunately, shattered, and that of John Lever, Obst. Physician, removed. Finally, the visitors were dismissed from the premises without their trophy and, to quote a daily paper, as they returned home "some of them were without their shirts, some of them were limping." But the fires had been kindled; some in authority had poured on cold water and so steam was raised to form a procession for the parade of the red lion through the City to King's College in the Strand. The zealous welcome that King's afforded to the procession both obstructed the traffic and rendered "Reggie" particulate. Portions of the lion were from time to time delivered over the college walls. Thanks are due to the Borough Police for escorting the procession so far from their home ground with such good humour, and acknowledgments to the City Constabulary, who rescued several individuals from the midst of the turmoil, leading them to places of safety for comparatively small considerations, levied next day.

Obituary

GUY BELLINGHAM SMITH.

BY the death of Mr. Bellingham Smith, at his home at Felsted on April 19th, 1945, within a few days of his eightieth birthday Guy's has lost one of the last remaining links with the Staff of the nineteenth century and a most picturesque and lovable personality, as well as a fine surgeon.

Guy Bellingham Smith was the eldest of a large family of whom the youngest, Eric, also a Guy's man, is physician to St. George's. He was educated at St. Paul's School and entered Guy's in 1883. His great ability was quickly recognised, though it was somewhat unfortunate that he had to compete in the scholarship and prize examinations of his time with another brilliant student, Ernest Starling, who later acquired world fame as a physiologist. He qualified in 1888, taking the F.R.C.S. two years later, and during the next twelve years he held in turn the appointments of Surgical Registrar, Ophthalmic Assistant and Resident Surgeon at the South-Western Fever Hospital, where he became an adept at tracheotomies and mastoid operations. At this time he acquired an interest in morbid histology, which never left him and, in later years, his opinion on pathological problems was always listened to with respect at gynæcological meetings.

In 1903 he was appointed to the Obstetric Staff, of which he was senior surgeon from 1913 until his retirement in 1925. No doubt his long training in widely different branches of practice did much to develop the remarkable accuracy of clinical diagnosis and judgment which was characteristic of him, but he had also a natural *flair* for rapid and precise observation combined with a manual dexterity quite out of the ordinary, and it was not surprising that he quickly acquired great skill in obstetrics. As, however, his beds increased in number and his opportunities for surgery grew it was in the gynæcological field of his specialty that his gifts became most apparent, and it would be true to say that he entirely revolutionised the surgical technique of the Department, taking minutes where his predecessors had taken hours to perform difficult abdominal operations, yet without the appearance of haste and with an avoidance of rough handling, which ensured a swift convalescence to his patients. He never played to the gallery and he had a horror of anything which savoured of "showing off," but visitors to his theatre have expressed the opinion that he was the Hospital's best operator.

He had an extensive private practice, but his generous nature and his carelessness in the collection of fees made him easily imposed upon, and his practice was not nearly as lucrative as it should have been. His utter disregard of ostentation militated against financial success, and his wide interests outside medicine were a constant drag upon his private professional work. These interests lay in art in all its branches, though chiefly in prints, drawings and water-colour paintings, of which he was a well-known collector and connoisseur, whose advice was often sought by the British Museum experts and art dealers. But his appetite for collecting did not stop at pictures, and at different periods he amassed collections of English glass and furniture, Chinese porcelain and bronzes, Japanese sword hilts, and on one occasion, Kashmir stamps, his only excursion into philately. It was characteristic of him that whatever interested him at the moment claimed all his leisure hours and he had an amazing faculty of acquiring an expert's knowledge of the subject in a surprisingly short time This meant many hours of concentrated study, and it was not to be wondered at that his practice suffered, but he never allowed his hobbies to interfere with his Hospital work.

It is difficult adequately to portray his lovable character as a man. Dear to his colleagues as "G. B." and to innumerable generations of students and house-surgeons as "Biff," his friendliness and cheery outlook on life made him countless friends, and his ready wit and wide and profound knowledge of things outside medicine made him always a most delightful and stimulating companion. He had a great love of children, and the happiest moments of his life were probably spent in watching them and sharing in their games. He was devoted to Guy's, and it was a particular pleasure to him, on his retirement from the active staff, to be appointed a School Governor, a post which he held almost until his death.

R. D. C.

Clinical Discipline—(II)

By JOHN A. RYLE.

I.

OUR modern medicine, it has been suggested, is becoming departmentalised and mechanised and, in the process, is running the risk of becoming dehumanised. How, then, shall we recast our clinical discipline for the amendment of these defects? How should we combine to better purpose the lessons of experience and experiment? How train our senses to observe keenly and accurately and our minds to make good judgements and to learn the real and respective merits of the direct or personal approach and of our valuable accessory methods?

In our approach to the patient, who has embarrassments no less and often far greater than ours, and—however young we may be—is apt to stand in awe of our professional status, we should proceed with open friendliness and sympathy and employing the simplest possible forms af phrase and question. While we regard his features and his hands for manifestations of illness or anxiety and listen to his tale we should be trying to peep behind the curtain and to read the fuller story of both his illness and of his life and its main difficulties. Bald interrogations about the main facts of illness are not enough. More delicate probings and indirect encouragement may be needed to bring out some essential item of information and to engender a confidence which will help him to unfold a picture of a home, a period of trouble or of a fear that has too long gone unexpressed. Or sometimes a re-questioning when the physical examination is complete may reveal symptomatic or other evidence which we could not before have anticipated. Questions relating to daily functions—appetite, digestion, sleep, and bowel, bladder and menstrual rhythms—to weight fluctuations and to exercise, rest and holidays, and indulgences in alcohol and tobacco must become a part of the routine enquiry in every general medical case.

In respect of subjective enquiries a system, however much it may need to be varied in small ways from case to case, is just as necessary as a system of physical examination. It is not enough to note the fact of symptoms. The patient's own description, the quality and degree of a pain, its frequency and duration all have a physiological and so a diagnostic import. They teach us to think about and to interpret symptoms and not merely to record them. The examination of the body should clearly follow a disciplined plan although the thoroughness and sometimes the order of particular system studies is varied according to the age and state of the patient. Details—such as a flattening, curving or grooving of the finger-nails, a few petechial hæmorrhages, herpes labialis, a smooth tongue, pale conjunctivæ, a faint stridor, an unpleasant breath, an overcoat in summer, or an odd gait or mannerism, a silence or a flood of tears, are as worthy of record as an enlarged spleen, a pre-systolic murmur or an absent knee-jerk. Urine examinations, so constant a routine in hospital (but too often to-day, even in teaching hospitals, deputed to the clinical laboratory) should not be neglected in practice, although pressure of work and the organisation of surgeries and consulting-rooms and the lack of assistance under present conditions compel omissions that we have been taught not to accept. Immediate examination of urine, fæces and sputa with eye and nose can be as important and suggestive as a laboratory report. Failure to carry out a digital examination of the rectum or vagina continues to account for a very large number of missed or fatally delayed diagnoses. It is not an uncommon experience for the consulting physician to see cases of rectal carcinoma which have been treated for months or even years at spas or subjected to X-ray and stool examinations for presumed "colitis," but in which no digital examination has ever been made. The blood-pressure reading, which is to-day regarded as a necessary part of a health examination or a routine antenatal overhaul, or as a preliminary to life insurance, is an even more necessary routine in all cases presenting cardiovascular symptoms, in all general medical examinations carried out on patients at or after middle life and in some younger subjects. Like the pulse and respiration-rate and weight, it is a numerical assessment and as such should be carefully recorded.

It may be objected that the "complete overhaul" which is possible in hospital and upon which the consultant can afford to spend as much as an hour is outside practical politics for the general practitioner with busy surgeries and thirty visits a day. Under our existing individual and non-co-operative system of practice, with its lack of ancillary service in the shape of secretary and nurse and of convenient

accommodation, it will always remain impossible for the driven doctor to give the time he would like to give to all his patients. Nevertheless, the family doctor with a good system and a good conscience commits very few serious errors. He has the advantage over the consultant that he knows, or soon gets to know, his patients more or less intimately and is informed about their domestic background, their economic status and the personal peculiarities of most of those on his lists. All this helps him to know when special time must be set aside for a fuller examination and what are the likely or unlikely explanations of particular manifestations of ill-health. He learns what omissions can be allowed and what chances can be fairly taken. A special examination impossible on one occasion can be made at a subsequent visit. A complete overhaul need not always be concluded at one time. Let us suppose that young Mrs. A. is looking thin and tired and admits to a poor appetite when she comes for a cough-mixture one evening. A few discreet questions, a note of the pulse-rate and temperature, a look at the throat may be all that time will then allow, but her doctor can arrange an appointment for a general and chest examination on a subsequent date. Or hard-working Mr. B. may complain of pain in his chest on hurrying for his train. He can be given temporary advice and told to stay in bed at the week-end for a rest and an examination of heart and blood-pressure and to have a specimen of urine ready when the doctor comes. Or the very anxious spinster, Miss C., who may be hiding a cancer-phobia, can be given special time for a careful examination and a reassuring talk.

Reassurance, once decided upon, should always be emphatic, diagnoses and treatments simply explained. They are the necessary conclusion to every careful examination.

II.

This brings us to a closer consideration of "system" as a part of clinical discipline. System is necessary in three particular spheres of action. Firstly, in the general arrangement of one's life and work; secondly, in respect of one's routine clinical methods; and, thirdly, in the keeping of records. Many young men and women are pitchforked into practice, or in war-time into a service, with little knowledge of what to expect. They try to apply what they have learned in hospital and find that the surgery or sick-parade takes far too long; they feel the lack of surrounding colleagues and instrumental and laboratory aids; they discover that they know little about the purchasing power of a labourer's wage in respect of food and of things deemed necessary in sickness; or they discover that they cannot tell the sick man's wife anything precise about a diet and its preparation or the mother about the management of a feverish child; or that they cannot at first readily distinguish the sick soldier from the unhappy soldier or the "lead-swinger." In brief, they do not yet know much about men and women and children and the way they live and feel. The rich man and the poor, the officer and the private, may have the same disease and yet present very different problems for solution.

The arrangement of days, hours and minutes becomes very important if the work is to get done at all, and yet to appear in a hurry, to be impatient or to miss an appointment are bad in practice and contribute to muddle and make for sketchy and unsatisfactory work. An untidy consulting-room, accumulating letters or journals, misplaced records lead to over-time at the day's end and so to increased fatigue and worry. Small wonder that some planners look forward ultimately to group-practice based upon a well-organised health-centre, with a sharing of medical duties and difficulties, a secretary and an appointment system and a nurse, and an association (both official and friendly) with the neighbouring hospital on the one hand and the public health authority on the other. The lack of system in some town and country practices must have been seen to be believed. In such practices all the orderliness obtaining in a good hospital, all the clinical discipline that has been instilled in the wards, seems to have been forgotten and the patients and the doctor suffer. Where there is lack of organisation in the practice there, too, the rules of clinical conduct tend to go by the board. Urines do not get examined, sketchy and partial physical examinations are made and shirts are not removed for examinations of chest and abdomen. Prescriptions are given in a "hit and miss" fashion and the "treatment without diagnosis," which Sir Arthur Newsholme* found so common among wage-earners and so much deplored inevitably prevails. How different and refreshing it is to go from a consultation with a muddled colleague, whose notes are bad or non-existent, to a consultation with another whose house and filing cabinet and dispensary are in order, whose evidence on the case is clearly marshalled, whose rapid sketch of a domestic situation or of the personal peculiarities of the patient and his relatives tell the essentials of the story before ever the consultant takes up hs cue.

* "Medicine and the State." London, 1932.

III.

System in physical examinations is not dinned into the clerk and dresser by the registrar or senior teacher solely to get him through examinations, but also to give him the foundations necessary for a good and enduring discipline in his future life and work. It is well, for these reasons, to develop a definite order or pattern for one's conduct of an examination and—with minor modifications dictated by time and circumstance, by the type of patient and degree of illness—to adhere strictly to it. Only so can we be sure at subsequent examinations that particular findings were or were not in evidence before. Only so can we feel justified in omitting negative entries in the notes and so condensing them. It goes without saying that in the case of acute illness, in the infant and in the tired and old we adapt our methods to suit immediate needs. Examinations may then have to be quick and partial. In the routine overhaul, however, general observations on build, facies, colour and temperament, are conveniently succeeded by the inspection of tongue, teeth, gums and fauces, and (since we are using the torch) of the pupillary reflexes. While the pulse-rate is taken the nails and skin can be studied. Inspection and palpation of the abdomen is followed by examination of the heart and lungs. Covering the trunk again, legs and feet are examined for œdema or scars or skin peculiarities, and the knee and ankle jerks and plantar responses elicited. Blood-pressure and ophthalmoscopy come last, unless a special examination of hernial orifices, genitalia or rectum is indicated. While the patient is dressing the urine can be tested. Women patients should be instructed to bring a morning specimen with them. Men can as conveniently pass theirs at the time. Specimens not tested at once should be labelled. A physical examination of this kind, when the patient is already known, can be completed in half-an-hour. If the patient is being seen for the first time and a full history must be taken and a further ten to twenty minutes left for explanation and advice and reassurance and a last word with a relative, at least three-quarters of an hour must be allowed and a full hour is often necessary. The consulting physician should not try to work to a quicker schedule. As indicated above, the general practitioner may know so much about his patient from previous interviews or examinations and his knowledge of the domestic situation that when, in the face of new symptoms or for life assurance purposes, a complete overhaul becomes necessary, twenty to thirty minutes may suffice.

Two sayings of patients at the end of an examination—both of them, alas, heard on a number of occasions—remain in my mind after twenty years of private and hospital consulting work: "This is the first time I've ever been asked to undress" and "I suppose you are not going to tell me anything." What a commentary on earlier experience! No examination worthy of the name can be made through clothing or an open shirt. No patient should be sent on his way without an opinion, an explanation or plan of action and, whenever possible, a comforting word. Far too many service men have been passed from hospital to hospital and board to board in the present war, often after much investigation, without ever being clearly told what was the matter with them or what their prospects were. The uncommunicative or over-cautious doctor can be a potent cause of anxiety, delayed recovery or confirmed illness.

Report of the York Clinic

By FELIX W. BROWN, D.M., M.R.C.P.

THE York Clinic owes its inception to the generosity of the York Trust. It has, in its situation as the first British psychiatric in-patient clinic in a general hospital, peculiar advantages over other establishments in this country for treatment of psychiatric patients. It is necessary to enumerate only some of these—the accessibility of the whole of the facilities of Guy's; opportunity of consultation with the surgical, general and medical staff about patients; and the nursing of our patients by Guy's nurses. It is particularly helpful for a psychiatric clinic to develop, not in isolation as has so often been necessary in the past, but in close association with the tradition of general medicine.

It was expected, however, that the York Clinic would not be able to admit psychiatric patients until after the War; but the foresight of the York Council in proceeding with the building has been justified, for in December, 1943, the opening of the Clinic for the purpose for which it was built was urgently requested by the Ministry of Health to provide beds for psychiatric casualties occurring among officers of the Services. An immense amount of work had to be done to furnish and equip

the Clinic and prepare the organisation, by Dr. Gillespie and Mr. Lees Read and by the nursing staff, and the Clinic was duly opened on 3rd April, 1944.

ADMISSION OF PATIENTS.

The E.M.S. patients are admitted on the advice of a Service psychiatrist. Thirty-eight of the total beds are earmarked for the E.M.S., but when all of these are not used by the E.M.S., private patients have been admitted to them. Private patients are admitted on the recommendation of a psychiatrist or in urgent cases by direct application from their own doctors to the Clinic. The criteria for admission are :—

(i) that the patient should be willing to accept treatment in the Clinic ; and

(ii) that the patient should be likely to benefit by admission.

From April 3rd to December 31st, 1944, there have been 112 E.M.S. admissions and 59 private admissions. Of these three were readmissions.

A precedent has been made by admission of a few non-paying patients from the general wards of Guy's. It is hoped that this facility will in future be able to be extended.

Although there are only forty-three beds, the number of patients passing through the Clinic in nine months has been 168, and in the whole year it will prove to be over 220. This entails an extremely rapid turnover in the Clinic, and the average stay for Service patients has been forty-three days, and for private patients forty-four days. A much wider experience is thus available for the nurses and staff attached to the Clinic than the number of beds would suggest.

TABLE SHOWING TYPES OF ILLNESS TREATED AT THE YORK CLINIC

Diagnosis.	Males.				Females.				Total.			
	Much Imp.	Imp.	Not Imp.	Total	Much Imp.	Imp.	Not Imp.	Total	Much Imp.	Imp.	Not Imp.	Total
Anxiety state ..	34	19	–	53	6	1	–	7	40	20	–	60
Hysteria	2	2	1	5	10	4	2	16	12	6	3	21
Obsessional state..	–	1	–	1	–	–	–	–	–	1	–	1
Anorexia nervosa..	–	–	–	–	–	2	–	2	–	2	–	2
Affective psychosis (depression).	4	3	1	8	3	1	2	6	7	4	3	14
Mania and hypomania.	2	–	–	2	–	1	–	1	2	1	–	3
Schizophrenia ..	–	2	2	4	–	–	1	1	–	2	3	5
Psychopathic personality.	–	3	–	3	–	1	1	2	–	4	1	5
Addiction	1	1	1	3	–	–	–	–	1	1	1	3
Organic Reaction..	–	2	1	3	1	1	1	3	1	3	2	6
Organic disease ..	2	1	4	7	–	–	–	–	2	1	4	7
Toxic and deficiency state.	2	–	–	2	2	1	–	3	4	1	–	5
Combat exhaustion	23	2	–	25	–	–	–	–	23	2	–	25
Post-concussional state.	3	2	–	5	–	1	–	1	3	3	–	6
Paranoid state ..	1	3	–	4	1	–	–	1	2	3	–	5
Total ..	74	41	10	125	23	13	7	43	97	54	17	168
Percentage ..	59 %	33 %	8 %	100 %	54 %	30 %	16 %	100 %	58 %	32 %	10 %	100 %

TYPES OF CONDITIONS TREATED.

The table gives an indication of the types of illness treated in the Clinic. No classification is completely satisfactory, as psychiatric illnesses are not definite diseases, but rather complex reaction types of the whole personality, showing as much variety and infinite gradation as human personality. The sixty cases of anxiety state, for instance, include many minor depressive reactions, and comprise much the same group as Rogerson calls " affective neurosis." Twenty-five cases of combat exhaustion have been treated here. This is the term used to cover psychiatric casualties occurring in the battlefield, in place of the discarded term " shell-shock " used in the last war. It is in many ways an apt term, as physical exhaustion often plays a large part in these conditions. They were given sleep treatment up to a week in duration, depending on the severity of the case, and then they were allowed to mix in the general life of the Clinic. Very often forgotten causes of nervousness dating back into early life are re-activated by their experiences, and the patients required discussion and reassurance on these topics. A phase of depression and then of irritability and fault-

finding often tended to appear, but when these were dealt with, the patient was usually able to leave the Clinic recovered in about three weeks to a month. Only one case of combat exhaustion ; a young lad admitted in an extremely acute excitement with hallucinations, had to be boarded out of the Service from the Clinic, and he was able to take up work as a schoolmaster after leaving. It was necessary, of course, to discharge many of the patients in lower medical categories at least for a while, but we have since heard that some of these patients have been able to return to active service again. A young tank commander, for instance, was admitted in a state of blindness after a shell had exploded in the cockpit of his tank. Under narcosis his sight was able to be returned and, after five weeks in the Clinic, he was able to return to duty. He is now commanding a tank again.

We have been glad to have in the Clinic several returned prisoners-of-war. These men often need considerable help in adjusting to life in this country again, and in overcoming the reaction of disillusionment and bitterness that can so easily develop if they are neglected. The York Clinic is particularly suitable for treatment of this kind of patient, as every stage of their adjustment to completely normal life in London can occur under observation in the Clinic. All ex-prisoners-of-war suffering from psychoneurotic symptoms have been able to return to normal life.

Most of the service cases admitted to the Clinic have been suffering from various degrees of maladjustment to Service conditions. Some of these were suffering from definite psychoneuroses which required detailed treatment, but in many of them the main function of the Clinic was to observe and assess their temperamental and intellectual capabilities, so that an appropriate recommendation could be made to the medical board about their future placement. Army medical boards have been held at the Clinic every fortnight, and the R.A.F. and Naval patients have been sent to their headquarters for boarding. Thirty-six of the 112 E.M.S. cases have been boarded out of the Service from the Clinic.

The civilian patients have for the most part been suffering from more severe degrees of psychological abnormality than the Service patients, and a greater variety of clinical conditions has thereby been able to be admitted. It has been found practicable to mix civilian and service patients of both sexes with mutual advantage. Both in the wards and in the common rooms there is no segregation of the sexes.

YORK CLINIC DURING THE FLYING-BOMB ATTACKS.

The arrival of the combat exhaustion patients in July and August coincided with the height of the flying-bomb attacks on London. At first the flying-bombs caused considerable anxiety among the combat exhaustion patients, but, after a while, they became desensitised to the various noises. The flying-bombs can be said to have had, in this respect, a helpful effect in the therapy of the patients, though what the effect would have been had the Clinic been damaged we fortunately had no opportunity to judge. It was remarkable to observe how completely unaffected were the well-established pyschoneurotics whose concern over their own problems was so great that they showed much less than the normal degree of anxiety at the approach of the flying-bomb. For several months during 1944 the patients all slept in the basement. This caused considerable extra work and inconvenience, especially to the nursing staff, but it was borne patiently while it lasted.

METHODS OF TREATMENT.

During recent years there has been a reaction in the direction of physical treatment of psychiatric illness. This is, however, an addition to rather than a substitution for, the well-established psychological methods. Illness is not regarded as either organic or functional, but rather due to a combination of both the organic and psychological sets of factors. The diagnosis of physical illness thus is an important preliminary to treatment in the Clinic, and we have received every possible assistance from the pathological and X-ray departments, and from the medical and surgical consulting staff of Guy's. We have full facilities at Guy's for the modern physical methods of treatment of psychiatric disorders. Briefly enumerated, these are :—

1. *Electric Convulsive Therapy.*—We have two sets of apparatus for this treatment which is singularly effective in cutting short the duration of severe depressive illness. The rehabilitation of the patient to ordinary life is, in many ways, the most important part of the treatment of a patient who has had convulsive therapy, and this requires much encouragement, gradually increased responsibility, and planning for the future.

The physical treatment of convulsive therapy can be regarded as a means to render the patient accessible to commonsense psychotherapeutic approach.

2. *Insulin Therapy.*—The method of insulin therapy used at Sutton Hospital was followed in appropriate cases. The main purpose of this treatment is to enable lean and undernourished patients to regain their appetite and normal weight, and thereby also their emotional resilience. We have also used this in conjunction with electric convulsive therapy with satisfactory results.

3. *Continuous Narcosis.*—Severly agitated and emotionally distressed patients are much benefited by a long period of sleep. This was found particularly useful with the acute cases of combat exhaustion from the front. Usually three or four days of about sixteen hours' sleep a day were found to be sufficient.

4. *Hydrotherapy.*—The continuous warm bath, though recently it has tended to be forgotten, has been found to play a definite and useful part in the treatment of severe agitation and excitement, and should be retained in conjunction with other methods of physical treatment.

5. *Vitamin Therapy.*—Several cases showing restlessness and slight confusion in elderly people have responded extremely well to Vitamin B therapy even in the absence of any physical evidence of diet deficiency.

6. *Psychotherapy.*—A full analysis of the factors, both constitutional and environmental, responsible for the patient's breakdown has to be made in every case. These factors are discussed with the patient in the interviews, with gradually increasing emphasis in the later interviews on planning for the future. This is essentially the method termed "distributive analysis" by Adolf Meyer. In a few cases Freudian psycho-analytic procedure has been followed, but this has not been found practicable in treating a group of in-patients such as we have in the Clinic. Frequently the procedure known as "narco-analysis" has been found useful as an aid to psychotherapy. This consists in giving a drug, such as evipan or sodium amytal, which has the effect of relaxing the tension in a patient so that matters can be faced, discussed and resolved much more rapidly than would otherwise be possible. A most profitable part of the psychological treatment is that of topical analysis. This means the analysis and discussion of the day-to-day problems of the patient in the Clinic—his reaction to the other patients, the Clinic routine, to transfer from a room or cubicle, etc. The design of the Clinic into rooms or cubicles provides an excellent opportunity for bringing about the socialisation of patients in this way.

A particularly effective method of rehabilitation is rendered possible by the situation of the York Clinic in London. Patients, towards the end of their stay in the Clinic, have been able to go out to work in their normal occupations during the day, and return at night to gain the benefit of the security of the Clinic until their confidence completely returns. Other patients are able to take regular courses of study in London—training in printing, secretarial work, or reading for the Bar, to give three examples. Throughout this last stage in adjustment some psychotherapy has to be maintained. Particular attention, in fact, has to be paid to what the patient does on leaving the Clinic. In fact, one can almost say that the prognosis of a patient depends on his making the right plans and finding the appropriate employment and environment on discharge.

Adequate psychotherapy is an extremely time-consuming procedure, and we have been handicapped by having only two on our medical staff.

7. *Social Activity.*—The organisation of the social life of the Clinic is one of the most important therapeutic agents. The patients from time to time elect committees to organise weekly dances, charades, musical evenings, debates and games tournaments. We are extremely grateful to the Clubs' Union for the loan of the squash court in the mornings. It has been much appreciated by the patients. An excellent selection of books has been supplied by Mrs. Buchanan from the Guy's Red Cross Library.

8. *Occupational Therapy.*—Though we lack the workshops and farming and gardening facilities of many clinics, Miss Dallow has been able to build up an extremely interesting occupational therapy department. Leather work, carpentry, work with plastics and model-making have been the most popular activities, but it is hoped to include pottery-making and, perhaps, metal-work shortly. Student occupational therapists from Miss Tarrant's College at Hampstead are being trained in the York Clinic by Miss Dallow. This has reacted to our mutual benefit.

NURSING.

In addition to our trained staff of nurses, Guy's probationers work in the York Clinic for three months. They receive regular teaching from the medical staff and sisters. This should prove to be a valuable addition to the training of a Guy's nurse. It is hoped that we shall shortly be recognised by the General Nursing Council as a hospital capable of providing training for the State-registered Mental Nurses' Certificate. We have several excellent general trained sisters who are anxious to take such a certificate. The whole matter is under discussion and it is possible that a joint arrangement might be made between the York Clinic and the Cassell Hospital. Qualified nurses who have worked well in the York Clinic undoubtedly deserve some official recognition. The nurses have maintained their keenness and have made the utmost use of their opportunity to study this branch of medicine.

TEACHING.

A weekly lecture is held in the York Clinic, and Guy's students have been allotted patients. They have been able to assist with the work on many occasions and it is hoped that in the future the student teaching facilities will be increased.

FUTURE PLANNING.

(a) *Ex-Service Men.*—An important post-war problem is bound to be the treatment and employment of men who have been discharged from the Services for phychiatric reasons. We have discussed the matter with Mr. Howard, of the Ex-Services Welfare Society, and it is hoped to allot a number of beds in the York Clinic for the treatment of such patients.

(b) *Post-Graduate Teaching.*—The development in the York Clinic of a post-graduate training centre is worthy of immediate consideration. We have excellent opportunities to provide the right kind of training for future psychiatrists. An increase in the medical staff and the provision of training and research fellowships would be needed to make full use of these opportunities. In addition, we hope to improve the facilities for research and investigation in the Clinic by the establishment of an electro-encephalograph unit.

CONCLUSION.

The York Clinic has now become an established part of the psychiatric service of the country, and though difficulties inevitably occur in the origination of a unit such as this, yet they have been overcome. Steps have already been made to carry out the wishes of the anonymous donor, that the Clinic should be made available to all classes of patient. There is no doubt that the demand for treatment by modern psychiatric methods outside a mental hospital is a growing one, and in fulfilling these needs the York Clinic can prove worthy of its parent hospital.

Correspondence

BELSEN CONCENTRATION CAMP.

To the Editor of the GAZETTE.

SIR,—This will probably be the first correspondence to reach Guy's from this concentration camp at Belsen, Germany. I hope it won't be the last !

The majority of us—and there are ninety-five medical students here from various London hospitals—did not arrive in Germany until last Wednesday (May 2nd). The delay in our journey was due to the cold weather which prevented flying. We stayed at an Army staging camp whilst awaiting for the weather to change, and life there was rather grim. The facilities for washing, eating, and even sleeping were, to say the least, primitive in the extreme. Each morning for four days we were called at either four or three a.m. and, after breakfast, were transported to an icy aerodrome—only to wait around and freeze. On the second morning the powers-that-be decided that we should take off. There were six planes for us and our equipment—so we had sixteen to one plane. Five aircraft took off ; the sixth never left the ground, as it received the weather report in time. Of the five airborne craft, one returned to base after one and a half hours, two (my own included) reached the coast and were then taken to Croydon, as our carburettors had frozen and ice had started forming on the wings—a factor which, apparently, renders the prognosis of a Dakota's existence somewhat unfavourable. Two planes continued ; one reached Brussels and there landed, whence, the

following day, the occupants were transported to Celle, our destination; the other managed to reach Celle quite safely.

The sixty-five of us still in England reassembled at the staging camp and, finally, on Wednesday, May 2nd, we got to Germany after an extremely pleasant three and a half hours' flight.

Belsen is about eighteen miles from Celle, the nearest air strip, and, although I am told there is a village here, I have yet to see it. It is the concentration camp that has mattered to people—not the village.

As the days go by the number of internees in the camp grows less and less, partly because of evacuations (official and unofficial) and partly because of deaths. The mortality rate when we first came here was about seven hundred per day and there were 27,000 inhabitants. The mortality rate now is about sixty per day and the population about 14,000.

The predigested food, casein hydrolysate, is having a dramatic effect on the very bad cases, especially those with famine œdema. In spite of its unpalatability we manage to persuade the sick to drink it and, as a further inducement, are endeavouring to add various flavourings like oxo and bovril. Unfortunately we suffer from a serious lack of œsophageal and nasal tubes, and so we cannot, at the moment, hope for such good results as we desire.

The drugs available at the camp dispensary consist chiefly of opium tablets (0.03 grain), sulphathiazole (0.5 gramme), aspirin, and the German preparation tanalbin (tannic acid and albumen), used as a cure for diarrhœa—a general complaint, not confined solely to the internees.

The most prevalent diseases in the camp are typhus, dysentery, and pulmonary tuberculosis, but, quite naturally, there are phenomenal numbers of bed sores, abscesses, and other septic lesions resulting from the filthy living conditions of these unfortunate people. There are many cases of parotitis, complicating typhus, and many severe incidents of stomatitis—for example, thrush. An unexpected finding is the very small number of cases of scurvy, as the vitamin C intake of these people must, during their stay here, have been practically nil.

As some huts are cleared so they are cleaned and disinfected and converted into hospital huts. There is also a hospital just outside the main concentration camp, situated near the quarters we now occupy, formerly the blocks housing the resident S.S. (*Schulag Staffel*) guards. Apart from the increased cleanliness of these hospital blocks, there are few facilities here in the way of drugs available in the camp. Certainly there are more fully qualified doctors present!

Before entering hospital each internee patient is taken to the human laundry where, under the supervision of German military doctors, German nurses scrub them thoroughly with soap and water and then dust them with delousing powder (D.D.T.).

I hope to be able to let you have more news of medical interest in my next letter as, by that time, we hope to have more equipment and treatment, even in the camp huts, will be following more on the lines of a diagnosis rather than symptomatic. We also hope that more surgical facilities will offer themselves as soon as we can approach any degree of asepsis—for, at the moment, the Belsen penknife incision is, of necessity, much in vogue.

Yours, etc.,

British Red Cross Commission, Belsen. DENNIS H. FORSDICK.

Sport

Boxing

LONDON UNIVERSITY CHAMPIONSHIPS.

Team Championship won by Guy's.

On Wednesday, May 9th, 1945, the Individual and Team Championships were held at No. 61 Arch, St. Thomas's Street, S.E.1, under the jurisdiction of the A.B.A. and the auspices of "M" Division Athletic Club, Tower Bridge Station. This was the first occasion on which the competition had been held for six years, and by happy coincidence the date arranged proved to be the first day of peace in Europe. Two days previously preliminaries had been held in the gymnasium at Guy's, so that the evening's programme consisted of finals and semi-finals only.

The Welter Weight (10st. 7lb.) semi-finals were boxed first, and in the first of these S. F. A. Westgate, of Guy's, narrowly lost to J. M. McCoy, of St. Thomas's, in what was probably the best bout of the evening. McCoy built up a large lead in the first two rounds owing to his speed and excellent left; Westgate's effort, in the last round, when he attacked strongly with both hands, more than once having McCoy in difficulties, just failed to make up the lost ground. In the second semi-final, J. G. R. Richardson, of the London, easily beat F. B. Heilbronn, of Imperial College

In the Light Heavy division (12st. 7lb.) T. O. K. Spraggs, Imperial College, outboxed Ogodazi, Imperial College, the referee stopping the fight in the first round. In the second bout

R. D. Walsh, of Guy's, met D. D. Miller, of St. Mary's, and lost on points.

Guy's had two representatives in the Middle Weight (11st. 6lb.) semi-finals: M. P. O'Reilly and J. F. Shaw. O'Reilly boxed P. G. Dyson, of Imperial College, and, although he hit hard with both hands, he was inclined to be wild against a quicker and cleverer opponent. Dyson won on points. In the other semi-final Shaw had an extremely hard bout with A. Rizler, of St. Mary's, both men hitting hard and frequently exchanging blow for blow. In the third round the referee disqualified Rizler for an illegal blow and awarded the decision to Shaw.

In the Featherweight semi-finals (9st.) A. Teuten, St. Mary's, easily outboxed I. Gramond, of Imperial College. M. Mason, of Guy's, boxed well to beat G. A. Simpson, of the London, in the other bout. Mason used his left cleverly, and was always ready to press home the advantage, frequently having his opponent in difficulties. He was a well-deserved winner.

Guy's had three representatives in the five finals, but, unfortunately, in the Middle Weight class, J. F. Shaw was compelled to withdraw owing to injury leaving P. G. Dyson to walk over.

In the Welter Weight final J. M. McCoy beat Richardson after a close and interesting contest, in which McCoy once again used his left to great advantage.

M. W. Harber, of Guy's, boxed N. M. Floyer, of the London, in the Heavy-weight final. Harber boxed well, but there was too much holding and leaning by both men in this bout. Floyer, a bigger and heavier man, was awarded the decision on points.

D. D. Miller won the Light Heavy division by beating T. O. K. Spriggs in the final. Miller was more aggressive than in the semi-final, and attacked to such good effect in the second round that the referee stopped the contest.

The last bout of the evening—the Feather-weight final—was won on points by A. Teuten, who beat M. Mason, of Guy's. Mason put up a very good performance against Teuten, who is a clever and experienced boxer.

After the conclusion of the bouts, the secretary of the London University Athletic Union, Mr. Kerslake, announced from the ring that the team championship had been won by Guy's, and pointed out that although the cup was at present in the country, he would ensure that it was returned as soon as possible and presented to Guy's. Mr. Kerslake then introduced to the audience the Mayoress of Bermondsey, Miss Loveland, W.A.A.F., and thanked her for so kindly consenting to be present and to give away the prizes. He also thanked "M" Division Athletic Club, especially Inspector C. Crowe and Sergeant A. Hills, for their kindness and efficiency in organising this tournament, the proceeds o which were devoted to Guy's Hospital.

Mr. G. A. R. Winston was a very able and efficient Master of Ceremonies, and our thanks are due to him and Mr. J. H. E. Winston for assistance in organisation and encouragement given to the Guy's team.

Guy's men will be very sorry to hear that Matt Wells, who trained with such enthusiasm the Guy's boxers, was taken ill three days before the contests and is still confined to bed. We wish him a very speedy recovery and return to the ringside.

SUMMARY OF RESULTS.

Fly Weight (8st.).—M. Coplans (Guy's). Walk-over.

Bantam Weight (8st. 6lb.).—R. L. Leader (Guy's). Walk-over.

Feather Weight (9st.)—A. Teuten (St. Mary's)

Light Weight (9st. 9lb.).—J. M. Pugh (Guy's) Walk-over.

Welter Weight (10st. 7lb.).—J. M. F. McCoy (St. Thomas's).

Middle Weight (11st. 6lb.).—P. G. Dyson (Imperial College). Walk-over.

Light Heavy Weight (12st. 7lb.).—D. D. Miller (St. Mary's).

Heavy Weight.—N. M. Floyer (London).

Special Bout.—N. H. Porter (Guy's) beat W. N. Wilkinson (St. George's) on points.

Hospital Information, etc.

Pass List

CONJOINT BOARD.
FINAL EXAMINATION.
March, 1945.

C. F. Allfrey	D. J. Rudman
J. P. M. Bensted	J. M. Thomas
E. L. Dutta	C. C. Vidot
J. C. Matthews	J. D. Whitehouse
J. N. Micklem	

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
L.D.S.

FIRST AND SECOND PROFESSIONAL EXAMINATIONS.
May, 1945.

Dental Metallurgy.

P. J. Attenborough	G. G. Phillips
L. Becker	D. Rabinowitz
E. J. Deutsch	B. S. Saunders
B. Engelsman	W. G. Selley
D. J. W. Foster	K. S. Sunaway
A. W. Hilliam	R. D. F. Thiel
G. Holding	G. P. J. Williams
J. D. Morgan	P. J. F. Woodroof

Dental Mechanics.

T. L. Barker	F. E. N. Preston
R. E. Feaver	S. F. A. Westgate
J. D. Morgan	

Anatomy and Physiology.

H. L. Lefcovitch	K. D. Watts
C. B. Palmer	

Special Anatomy and Physiology.

R. E. Feaver	R. A. J. Shaw
A. A. W. Fooks	A. Shotts
M. C. Grant	P. B. Smith
G. A. Kerr	M. J. L. Sykes
J. G. L. Knowles	J. R. Timms
F. E. N. Preston	J. R. Wallis
P. H. Prynne	E. J. Williams
F. M. Scherbel	

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
April, 1945.

Surgery.—J. C. Mathews.

Pathology, Bacteriology and Forensic Medicine.—J. Wotton.

Medicine.—D. J. Chapman, J. Wotton.

Midwifery.—D. J. Chapman.

Births

WADIA.—On May 3rd, 1945, in London, to the wife of Richard Wadia, Surg.-Lt., R.N.V.R.—a daughter.

EDS. {J.D.L.R. M.G.T.

ALOCOL

Colloidal Hydroxide of Aluminium

For Gastric or Duodenal Ulcer

IN view of the increasing adoption of intensive alkaline medication for gastric and duodenal ulceration, the selection of a suitable antacid agent is a matter of considerable importance to the general practitioner.

'Alocol' allows of antacid therapy in a particularly effective, safe and reliable form, and replaces with advantage mixtures composed of sodium bicarbonate, magnesia, bismuth, etc. It does not produce any unpleasant secondary reactions, even when taken in strong doses and over a long period of time.

'Alocol' neutralises excess gastric acidity to the most favourable degree without provoking the danger of alkalosis, thus producing a markedly soothing effect on the gastric mucosa, with the prompt relief of pain and discomfort.

Complete chemical history of "Alocol," with convincing clinical reports and supply for trial, sent free to physicians on request.

A. WANDER, LTD., *Manufacturing Chemists*
5 and 7, Albert Hall Mansions, London, S.W.7

Laboratories, Works and Farms: KING'S LANGLEY, HERTS.

M 317

'AVLON'

brand of

PHEMITONE B.P.

Phemitone (a derivative of barbituric acid) is recommended for the control of the incidence of epileptic fits.

Further information and technical literature will be forwarded on request.

PACKINGS

Phemitone tablets are available in two strengths:—½ *grain tablets in tubes of* 30 *and bottles of* 100 *and* 500. 3 *grain tablets in tubes of* 10 *and bottles of* 100 *and* 500.

Obtainable through your usual suppliers.

A Product of

IMPERIAL CHEMICAL [PHARMACEUTICALS] LTD.
89, OXFORD STREET, MANCHESTER, 1

Ph. 51c

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1484 *9th June, 1945* *Ninepence*

PASSIM

"AND their darkness shall be made light." This is the task to which the works department has for the last few days been applying itself. Such has been the battering down of brick blast walls, and such the casting of unnecessary black-outs, that it seems as though all the pent-up murk and darkness of six years has been suddenly released and allowed to dissolve away into the outer sunshine. Certain dark places still remain however; the Eye ward is one of them. There is no question here of uncovering windows and letting in daylight; the ward is virtually without windows—it was constructed for darkness. If the room were filled with ophthalmic patients this gloom would be satisfactory; if persistent air-raids demanded the continued existence of such a deep-set blast-proof reception ward, it would be justifiable; the absence of better accommodation might render it tolerable. But none of these conditions now operate; the number of ophthalmic in-patients do not at present warrant such extensive accommodation; we have finished with air-raids, and Lydia and Queen, now redecorated, wait upon the availability of domestic staff before they may receive patients. The re-opening of one of these old surgical wards, and the simultaneous closure of the Eye ward would make no additional calls on the domestic staff, however.

We are not suggesting that the Nursing Staff of Eyes are inconvenienced by miner's nystagmus when they go off duty, or that the patients, living under a system of *purdah*, are incapacitated by osteomalacia. But conditions necessitating individual scrutiny of each patient by the light of a portable electric lamp are obviously far from ideal.

ON Sunday, June 3rd, 1945 (Hospital Sunday), a special service was broadcast from Guy's Chapel. The Provost of Southwark Cathedral and the Hospital Chaplain officiated at the service, while the Matron gave an address, in which she laid emphasis on the universal and essential identity of hospital aims and ideals throughout the world, and on the unity of the charitable objective of each type of service that assists in the running of a hospital. The lesson was read by Professor Johnston. A choir of nurses and students, trained specially for the occasion, provided the singing, and perhaps one may record that their efforts were warmly commended by the official of the B.B.C. who organised the broadcast.

ON Wednesday, June 20th, 1945, the Nursing Staff at The Wildernesse are holding a garden fête in aid of the funds of the Sir Cosmo and Lady Bonsor Memorial Scholarship and the Hospital's Rebuilding scheme. It is hoped to raise £1,000, so book this date—Wednesday, June 20th, for The Wildernesse, Seal, Sevenoaks. Admission, 1*s*.

ON June 27th, 1945, a Victory Dance is to be held for the nurses and residents of the Hospital. Further particulars will be given in the next issue.

THE paper shortage is still very acute, and we cannot yet print nearly as many copies of the *Gazette* as we would like; so we should be very grateful if readers who do not wish to keep their copies would return them to the Library or *Gazette* Office after they have finished with them.

THE photographs that appeared in the last issue may be obtained from the *Gazette* office. They measure 8 in. by 6 in. and cost 2*s*. each.

Clinical Discipline—(III)

By JOHN A. RYLE.

I.

IN the matter of treatment the development and maintenance of a sound discipline is of particular importance to the doctor himself, but it should also come to be reflected in the nurses, patients and relatives who collaborate with him. It is very easy to fall into the habit of ordering proprietary remedies, as to the actions or inactions, the composition and even the cost of which we are often but scantily informed. It is as easy to fall into the habit of becoming a prescription writer and making the prescription the final flourish to a consultation, as though it had an importance with which it can rarely, in fact, be credited. We have only a handful of specific remedies and another handful of valuable symptomatic remedies of proved pharmacological value. To prescribe outside the range of these is mentally dishonest and bad education for the individual and the public; it involves the patient in unnecessary expense. But its worst influence, where the doctor is concerned, is that it tends to cultivate in him an undue belief in medicines and to distract his thought and attention from a more valid form of therapeutics involving physiological and psychological methods. If, instead of over-prescribing, a little more time were devoted in the surgery or consulting-room to sensible advice about regimen, habits, exercise, open windows and the discontinuance (instead of the advocacy or exchange) of purgatives; or, in the case of the more seriously sick, to rational physiological methods—fluid intake, posture, nursing management, oxygen administration, diet, quiet, and to graduating the stages of a convalescence; and, in all cases, to simple psychotherapy for the sick man and his relatives—patients everywhere would benefit, their trust and confidence would be extended and many a lurking dissatisfaction with his mission would be banished from the busy doctor's mind. Just as in diagnostic difficulties we should not shrink from saying to ourselves and others "I do not know," so, with many of the therapeutic suggestions with which we are tempted by the books or bombarded by the proprietary chemist we should not shrink from saying, "I do not believe." In being thus negative we need not surrender ourselves to inaction. When we say or suggest to a patient or relative that "we do not know," we can also indicate that there is, in fact, a clear case for the "watching brief," for a further investigation or for a consultation with a colleague; or that quick recovery (say, from an obscure pyrexia), without a precise diagnosis having been achieved, is a likely outcome of the moment's anxiety. When again we say that "we do not believe in it," in response to pressure brought to bear upon us to try this, that or another remedy (or, maybe, an operation), we do well to say precisely why we take this view and to explain how frequently in such cases recovery is due to time and Nature and the nurse. The advantages which attach to consideration for physiological and psychological needs can also be urged. Frankness and honest explanations generally inspire trust. Most patients and relatives are sensible enough to know that we are not the magicians they sometimes wish we were, but just physicians confronted daily with decisions, simple and difficult, and a host of very human anxieties. This mention of anxieties reminds me of another simple rule. Whenever anxiety is great judgement tends to waver. In serious illness, therefore, and especially in illness affecting a relative or friend, consultative help should be sought whenever possible.

II.

There are many other things which contribute to the maintenance of standards but which can be only briefly referred to here. Reading the journals, marking and filing articles of special value, membership of a medical society and a library—all these help to keep us "on our toes" and to cherish that interest without which discipline may degenerate into uninspired routine. Informal discussions or consultations with fellow practitioners or meetings with consultants should never be refused through any false sense of pride. We can remind ourselves with Hippocrates that "a physician's reasoning should never be jealous of another. To be so will be a sign of weakness." Ethical observances are an indirect contribution to clinical discipline, for they assist frank relationships with patients and with colleagues. Much can be learned from errors retraced and analysed. I have long regretted that I kept no separate record and index of mistakes.

Since personal health is necessary to the best conduct of a practice I should like, had space permitted, to have said something of how this, too, should be catered for, however heavy the demands of professional work may become. Suffice it to say, that the needless risking of health is poor economy and poor planning, and, as the Registrar-General's tables show, it cuts short and hampers the careers of too many in our exacting calling. Judgement is never at its best in the sick or weary man or woman. Without hobbies or relaxations a working life is never quite complete.

III.

We come next to the question of records. A card-index system is better than notebooks. The consulting physician will need three sets of cards relating to—(*a*) patients, (*b*) doctors, (*c*) diseases. On the patient's card name, age, address, civil state and date of examination are entered; on the doctor's card his name and address and the patients seen with or for him are inscribed in serial order; and on the disease cards the names and serial numbers of the patients seen below each heading. The patient's notes should be kept in individual folders, which will hold in addition letters from, and copies of letters to, colleagues and all laboratory and other reports. Each new patient takes the next serial number. If subsequently a patient's name cannot be remembered a reference to the disease or doctor index will provide it. If a paper or lecture on a particular disease or group of cases is in contemplation the disease index supplies the numbers of the files. For general practice, unless good secretarial assistance is available, the three card system and the separate files would be considered too elaborate. The countless small entries and minor short-term complaints would be difficult to keep up to date and annotated. Large cards bearing the patient's name, age, address, and dates of visits with spaces at the top—(*a*) for the provisional and (*b*) for the final diagnosis of main illnesses (new illnesses being entered below the original one with dates in each case) and a second set of cards for main diseases and carrying the names of the patients, reduce the filing to two sets of cards instead of three with a further set of case-sheets and files. The notes in this system are entered direct on the patient's card and continuation cards can be clipped to the first one. Better still, perhaps, is an open-edged envelope for each patient to take the cards together with all letters and reports. The patient's name is then clearly inscribed on the envelope and alphabetical filing instead of serial numerical filing is more convenient.

There is no more fundamental contribution to clinical discipline than good note-keeping. Entries should be made at the time or very soon afterwards whenever possible. Memory is a fickle jade. More and more in modern medicine we are coming to demand facts instead of those "impressions" upon which doctors have always been too ready to rely. Excepting in the case of the notifiable diseases we have no national morbidity statistics. If, as it is hoped, machinery for the collection of such statistics can be evolved it will become more than ever important that both hospital and private records should be well kept. The more often facts can be numerically stated the better. Dates, ages (preferably indicated by year of birth), weights, pulse-rates, temperature and blood-pressure readings, blood-counts—all these provide essential information and may serve as indices of adverse change or progress.

IV.

A word about the physician's tools. The doctor's bag and instrument cupboard should be carefully planned and neatly kept. Over and above stethoscope and sphygomanometer and the usual day-to-day requirements there are essentials which are often missing, if I am to judge by the experience of many town and country consultations. Film finger-stalls, electric torch, ophthalmoscope and auroscope, knee-jerk hammer, a tube of vaseline, and a rubber catheter and glass connection for the nasal administration of oxygen are examples which come to mind. Again and again I have had to supply the last-named at some winter's night consultation on a case of pneumonia or other cyanotic illness, and also to manipulate the oxygen cylinder and show the nurse how to pass the catheter and keep it in place and at what rate the oxygen should flow. A rectal tube and funnel have important uses. Although not frequently needed a stomach tube with Senoran's evacuator is invaluable in some cases of poisoning and in gastric dilatation due to pyloric obstruction or occurring after operations. In the latter case a small stomach tube and syphonage should succeed the initial lavage. If he feels competent to use them the doctor should also keep in his surgery lumbar puncture needles and Record syringes for intravenous medication and the collection of blood samples. Clean, dry slides and a hæmoglobinometer for the quick reading of a blood picture take little room and in less than quarter of an hour can often com-

plete a diagnosis, decide the nature and degree of an anæmia and determine the necessary treatment with iron or liver or some other action. A hand centrifuge makes it quickly possible to examine urinary sediments under the microscope at home. Of the drugs which may be necessary in urgent situations and which I would always wish to carry with me, the following may be mentioned—adrenalin for acute asthmatic attacks, pituitrin for meteorism and obstetric cases, insulin for diabetic coma and a reliable digitalis preparation, in addition to the usual morphine and atropine. A sterile hypodermic syringe in its own container and ampoules (which are always preferable to preparations in tablet form) can save appreciable time and trouble.

V.

The training of the senses in observation, the training of the mind and critical faculty in the collection and use of evidence, the regulation of the days, the gradual education of understanding and sympathy, the control of temper in difficult situations, the adaptation of speech and mood to suit each patient and to minimise fears and secure confidence—all these are part of our arduous self-discipline. A due regard for ætiological, pathological and therapeutic principles in clinical assessments, the readiness to agree to a consultation, the elimination of professional jealousies, and a sense of service both to the individual and to the community—all these go to the slow development of our standards. Our studies to-day should more consciously envisage the effects of social circumstance on ill-health and of ill-health on social circumstance. Clinical and social medicine are very close co-partners. Because the science of medicine is—for most of us—observational rather than experimental, it need not cease to be science. The natural history of disease patiently studied in the field, can be as valuable as the more detailed investigations of the laboratory. The two are complementary. For both statistical controls in expert hands will become more and more necessary. To make these possible good records are essential. Of the minority, who devote their lives to theoretical medicine, it must be required that their experiments are conducted with a humanity as conscious and considerate as that deemed necessary in a general or consulting practice; of the majority that they do not allow their critical faculty to become submerged through pressure of work. Together the vocational and the theoretical physician can rebuild a discipline which has begun to disintegrate under the influence of a too rapid rate of technical advance. In the planning, sharing and fulfilment of their tasks they should not ignore the uses of historical retrospect and idealist philosophy. Interest alike in the good of the past and the better yet to be can inspire and balance thought and action, and help the growth of that scientific humanism which is the aim and purpose of all our medicine.

What to do with a Dead Body

By KEITH SIMPSON, M.D.

A Clinical Lecture delivered at Guy's Hospital on Tuesday, March 27th, 1945.

GENTLEMEN,—I have a shrewd suspicion that your enthusiasm is not entirely due to fervour for forensic medicine; that you anticipate from the title of this lecture that I am about to tell you how, quietly and without fuss, to dispose of that traditional menace—the mother-in-law. I shall not disappoint you, but we have more everyday matters to dispose of first.

When a doctor is called to a person who is thought to be dead he has three principal duties. The first is to make sure that death has in fact taken place, and, as a corollary to that, if he can say, how long ago death took place. The second duty he has is to issue a certificate if he is in a position to do so, or, if not, to refer the case for inquiry. His third duty is to keep his eyes wide open for any medical grounds for suspicion.

1. HAS DEATH TAKEN PLACE: IF SO WHEN.

On the first question as to whether death has in fact taken place: in the large majority of instances there will be no doubt about the matter. This case of which I show you a photograph is that of an old woman whose body was found, evidently some weeks after her death, in bombed-out premises, where there had been no food or shelter of any kind, the body being in a dried mummified condition, almost crumbling. You will not have a great deal of difficulty as medical men in arriving at the conclusion in such a case as this that death has taken place! But when pre-

sented with a person freshly dead you may have some difficulty. Suspended animation due to shock—sometimes electrical shock, sometimes shock from immersion—may give rise to difficulty, and you may not be very happy in saying that death has in fact taken place and that the body can be disposed of. You will not, I hope, waste your time in searching for a suitable feather to hold in front of the nostrils or mouth, or in polishing up a mirror to see whether condensation takes place, or in tying a string around the finger. You will listen with your stethoscope for some sign of movement in the heart, and you will watch and listen for signs of breathing, for until both these cycles have ceased death has not taken place. If you have any doubt at all you will continue to try resuscitation, for hours if necessary, until you are satisfied that it is no longer of any use. If the first observation has to be made in the street, where there is too much noise to enable you to make it properly, you are entitled to summon an ambulance and have the body transferred to hospital. It is your duty if you think life may be present to go on making observations until you are satisfied in the other direction.

In the case the photograph of which I next show you, no change had taken place, with the exception of the cessation of respiration and circulation, at the time the woman was found, strangled and suffocated, in her hotel near Waterloo Station. In such cases—going on to our corollary—the ascertainment of the lapse of time since death is best carried out by the measurement of the temperature. During the first twenty-four to thirty-six hours the only condition in the dead body which progresses steadily is the fall in temperature. That is steady enough to enable you to obtain some idea of the lapse of time, bearing in mind the conditions of clothing, covering, state of nourishment of the body, and the surroundings, such as the amount of draught, and so on. In the case of a prostitute who was murdered with her own shillelagh at Brixton some ten days ago, there was still a measureable temperature in the body some thirty-six to forty hours after death. Never omit the precaution of taking the temperature when you are satisfied that death has taken place, in order that you may at a later stage give some estimate of the lapse of time after death.

Other post-mortem conditions—the development of rigor mortis, the appearance of livid stains in the skin, and the subsequent arrival of the process of decomposition—are all too uncertain to enable you to base any opinion on the lapse of time which has occurred. I want, however, to say one or two words about these changes from other angles. Decomposition may so far disturb the appearance of a body that it becomes literally unrecognisable within as short a lapse of time, in hot weather, as perhaps forty-eight hours. Another of your duties as doctors, observing decomposition to be in progress, would be to ask if identification of the body had taken place, and to impress upon any police-officer or other person responsible the importance of having some identification made or of having a photograph taken so that it could be made from a photograph at a later date when the body would be quite beyond recognition.

Not only will decomposition affect the appearance of the body : so also will injuries to the head and face, as in the case I show you in which a woman was beaten on the head and face with a stool, and after death tied up in four sacks, carried on a bicycle through the town of Luton, and tumbled into a stream. The features in such a case may be so disturbed that they are already almost unrecognisable. I show you one of the standard slides shown by Scotland Yard at cinemas throughout the country when a victim has not been identified and assistance is required for this purpose. In the Luton " sack-murder " this slide was shown in cinemas in the town, and a girl of seventeen, the daughter of the missing woman, saw it but failed to recognise the photograph. The case was held up for three months for identification, but within twenty-four hours of this being established the affair was cleared up, a charge of murder was made, and the man charged was subsequently convicted. I show photographs of that woman, as she was in life and after death, in order to show how rapidly the face can change and how difficult it may be for recognition to be effected.

If we go further with the process of decomposition, the tissues may become so disintegrated that recognition is not a matter any longer of looking at a photograph, but of reconstructing the height, sex, age, and colouring of the person from other findings. This is not a matter for us to consider here, but it is a matter for you and me to consider when we see such a body to record any piece of evidence which may enable us at a later stage to build up the identity of the person. The girl whose photograph I next show was murdered in some woods down in Surrey by a Canadian Red Indian and subsequently buried. The body was dragged up on a hill and buried

shallow in sandy soil, and for some weeks it was the prey of vermin—maggots in particular—which eventually precluded all possibility of recognition. When the last stage of this process of decomposition had taken place nothing was left in the way of features. All that was left was bare bone and a little slime and hair. This next woman's body, showing another disfiguring change, adipocere, came up with the roots of a tree on the bank of the river Rodin when the tree was being felled. The next time a tree was felled, in the following week, the body of a small child came up entangled in the roots, and for some time after that the work was abandoned, for the workmen had no wish to be involved in such complex tree-felling.

There is one other process of post-mortem change about which a word should be said, and that is mummification. This is a change which requires an entirely different atmosphere—warmth, indeed, but dry warmth, preferably with a good draught. In this case I show you a man who was found comfortably seated in a chair over a coffee-shop. The warm delicious fumes of the coffee had been passing up over the body for five or six months, resulting in a process of drying. Here you meet a condition which gives you greater difficulty in estimating the lapse of time than any other, for once the condition of drying has reached the stages preceding crumbling and disintegration the body may remain leathery, shrivelled, dried-up, looking exactly the same for months. All we can say is that, bearing in mind these conditions I have described, many months have elapsed since death took place. We can give only a rough estimate of time.

2. CERTIFICATION.

Coming to more mundane matters, the next duty of the doctor is to decide whether he is in a position to issue a certificate or not. A certificate of death is one which only a duly qualified and registered medical practitioner can sign. The law has never said that he must not charge a fee for it, but as it is a duty—a statutory duty—for him to fill it in if he is in a position to do so, and the law has not fixed a fee for it, it is presumed that no fee is charged. It would be dangerous, indeed, for a fee to be charged. Doctors might become popular for other than proper reasons and the covering up of criminal procedures might be encouraged to some extent.

The certificate itself is in the form of a central certificate proper, with two subsidiary detachable wings. The wing on the left is kept by the doctor for records of the certificates which he has issued. The other is what is called a notice to the informant; it is, in fact, nothing more than a notice to be taken to the registrar of births and deaths by some person qualified to give him information that the death of a person has taken place, to warn him that he should subsequently receive a death certificate from either the doctor or the coroner. Anyone who was present at death is qualified to act as informant—a relative, the housekeeper, the doctor himself. In one case which I examined a woman who had been entertaining a man friend overnight while her husband was on night duty was presented with a problem when her visitor died during the night. In that case the woman, naturally not wishing to be involved publicly, was relieved by the coroner's officer, who managed before seven in the morning to visit the premises, to dispose of the body through the kindness of an undertaker, and himself to act as informant.

In another case a prostitute had invited up to her flat the driver of a taxi which she had hired to drive her home. The taxi-driver died on her during the process, I presume, of settling the fare. Thus she had a body, a notice to the informant, and a taxi to dispose of.

The certificate makes it quite clear as you see that the doctor, duly qualified and registered, must have been in attendance during the last illness of the person to whom the certificate refers. That must be professional attendance. The doctor is not in a position to issue the certificate if he has merely seen the person now dead knocking about the premises when he has called there to examine some other person. He must have been in professional attendance during the last illness, and in this country that should have been within fourteen days of death. He must say on the certificate when he last saw the patient alive.

Unfortunately, he is not asked by law to see the body after death. That is a serious omission. How is the doctor to know there is a dead body at all without seeing it? But there it is: the law does not ask him to see the body after death. I have had many examples of a doctor attending a person for some illness likely to be fatal and being told that death had taken place, without himself verifying the statement, issuing a certificate; and then some person has raised the suspicion that death

was due to some entirely different cause, and autopsy has shown it to be so, perhaps to suicide, the patient being unable any longer to put up with the distressing illness taking his own life. You should never omit the precaution of going to see the body after death, even though the law does not require it.

As to filling in the cause of death: of course, if you have not been to see your patient during the last illness you will be quite unable to fill in the cause of death. The date when "last seen alive" by you—if over fourteen days previously—may cause the registrar to return the certificate to the coroner. But supposing you have seen your patient in life and during the last illness, you may still be unable to fill in the cause of death adequately because you do not know it. This part of the certificate asks you to state the immediate cause of death: 1 (*a*), and the morbid conditions which directly contributed to death: 1 (*b*). Under II you may enter any morbid condition of importance which might have a bearing on the cause of death. We might say the cause of death was acute general peritonitis due to perforation of an ileal ulcer, and that chronic pulmonary tuberculosis was an important morbid condition lying in the background. The process starts at the immediate precipitating cause of death.

Ambiguity should be avoided: *e.g.*, birth injuries, coma, morbus cordis and other odds and ends that have no very clear meaning. If the meaning is not clear the registrar will be likely to refer the certificate to the coroner. Avoid also the other extreme of being verbose, of writing a certificate in this form:—

> "Heart failure, arteriosclerosis, central arterial degeneration over a long time; December, 1936, hemiplegia and aphasia; September, 1937, intracerebral hæmorrhage; July, 1938, intracerebral hæmorrhage; August, 1938, heart attack." It is not a very helpful certificate.

Even if you have been in attendance during the last illness and know the cause of death you may still think it better not to fill the certificate in because there are certain circumstances under which the case should be referred for inquiry. I want to make this perfectly clear to you. In law you are still entitled to fill in a certificate because in law it is the registrar who is asked to refer the case for inquiry. There is on the back of this certificate a square which enables you to tell the registrar that with regard to the person whose particulars appear overleaf you desire to report the case to the coroner, or have, in fact, done so. You are quite entitled in law to do that, but in practice it will be a saving of time and a convenience if you yourself refer the case to the coroner and do not proceed by the devious route of reporting the case to the registrar as one requiring inquiry by the coroner. If you pass your certificate to the registrar and he later refers it to the coroner serious delay may take place. In law, therefore, it is the registrar who refers the case to the coroner, but in practice it is the doctor who saves time by reporting the case direct to the coroner.

What are the cases which demand this procedure? There is a group in which the doctor has not been in attendance during the last illness. In this country that means a maximum period of fourteen days before death. We might add as a corollary to that the cases in which the doctor is unable to give a certificate because he is away or himself unwell, or is unable to state the cause of death.

In a second group of cases lie the deaths which are due to accident or neglect or injury of any kind and of any date—whether or not the injury took place within a year and a day: also deaths under anæsthesia. In this group we should place cases of poisoning, including food poisoning and industrial poisoning, and, lastly, all suspicious cases of maternal and fœtal deaths, and any case about which there has been any doubt. There is a last group of cases to be reported to the coroner under a different legal enactment—namely, deaths in mental hospitals (other than those of voluntary patients) and in prison.

3. MEDICAL CAUSES FOR SUSPICION.

Now for the cases in which there is suspicion. Suspicion is aroused for one of two reasons, either because of the methods employed for the disposal of the body, or because of the character of injuries sustained. On methods of disposal I show, for example, a child's body found in a suit-case which had been left in the luggage department at Waterloo Station, and another case in which the body was found dismembered and partly burned, buried under a cellar floor. There can be hardly any doubt of foul play in cases like these.

There is one other case of this kind I want to show you. When a body is found trussed up it might appear to be a plain case of murder, and a fortnight ago I went down to Portsmouth and saw the body of a man trussed up in such a way that one would immediately suspect murder. In fact, it was later found that the man had left a note on board the ship on which he was serving showing that he intended suicide and, having a sailor's knowledge of ropes and knots, he had trussed himself up, hobbled to the water's edge and tumbled in.

In the case of children we are on much more secure ground, as there is much less likelihood of self-inflicted injuries. I show the picture of an infant who had evidently been gripped by the nostrils by a hand also covering the mouth, so that death took place from suffocation. The statement of the mother, an Irish hospital nurse, was that the child had been discovered dead at the bottom of the bed soon after delivery, and that she had done nothing to it, but the injuries betrayed her story to be false. It had been deliberately suffocated by hand.

We must not be too ready with our suspicions in the case of injuries in children, for sometimes the most extensive injuries produced by finger-nails and the hand over the face may have been sustained at birth, the mother, as in this case of an abandoned dead baby, making a frenzied attempt at self-delivery under conditions of great difficulty.

In adults there are some kinds of injury which are not very serious-looking, but which may well arouse suspicion. Here we have signs of manual strangulation, with marks of three fingers on one side of the neck and an opposing thumb mark, with some finger-nail scratches also, the victim being an old woman who was discovered dead on the floor in an upstairs room of a public-house in Portsmouth. This was clear evidence of murder, for no person can strangle herself by the hand; as she loses consciousness the hand falls away, the grip is relaxed. In the case quoted the hand that (almost without question) did this was a deformed hand. I was disturbed on hearing that the man who was arrested had no nails on the right hand which I had said must have caused the marks on the woman's neck. The scratch marks, however, were explained as having been caused by the woman herself in trying to release the grip.

Sometimes the situation of the injuries is sufficient to arouse suspicion. Injuries to the back of the body, on the whole, tend to arouse suspicion unless they are in keeping with a fall to the ground or some other equally simple explanation. Several blunt injuries to the back of the head must certainly arouse suspicion. In this case, of a club door-keeper found dying at Guildford, the injuries to the back of the head had been repaired surgically during life, and I had no hope, seeing this photograph, that it would be possible to deduce anything from them or the nature of the weapon by which they had been caused. But, to my great pleasure, the police-officer, who was out to pull my leg, took out of his book another photograph, showing the injuries before they had been stitched up, and said that in this case the local hospital doctor concerned—"a Guy's man, of course"—took the precaution of photographing the injuries before sewing them up.

Sometimes you will find a case in which numerous blows have been sustained on the front of the body where some protection could have been made against them by the hand, but the hands show no such signs. The indications are that the victim was felled and disabled by a single blow often lying apart, like this, from the rest, and that further blows were then sustained while he was unconscious.

You all know the ease with which the tentative, carefully selected, rather hesitant, nervous movements of a suicide in cutting his throat, as in this case, can be distinguished from the broad slashing cuts of a homicidal attack with a knife, like this. Similarly with stab wounds. In this photograph the site of the stabbing had been carefully selected. The man was found lying on his face in bed with a knife beneath him. The entry wound is at the spot in the epigastrium, where most persons think their heart to lie or know they will have no trouble in reaching it. Some love trouble was the cause in this case, his *fiancée* saying that he had grown cold lately. That kind of stab raises no suspicion. The suicidal stab will have a characteristic direction. There will seldom, as a rule, be much repetition and other characters may distinguish it. There are many other points to be remembered relating to the situation and number of wounds, the presumed direction of the attack, and the indication of resistance by the victim, shown, for example, in this case of extensive slashed and stabbed wounding with slashing of fingers which had endeavoured to protect the body from the knife.

In the case of bullet wounds the outstanding grounds for suspicion are much the same as have been described to you for other wounds—their situation and their number. Suicides using firearms exercise great care in election of site in the same way as a suicide with a razor carefully selects a site on his neck. The favoured sites I show you are the centre brow, the right temple (the left in a left-handed person), over the heart, and the roof of the mouth. Those are the common situations, and a situation a little outside of these, as in this case of a bargee murdered at Harwich, would be enough to arouse your suspicion. The other condition of firearm wounds which always arouses suspicion relates to the range. The arm's reach is about the limit at which some tattooing would be shown on the clothes or on the body itself. When the range is beyond three feet—approximately arm's length—there is likely to be no tattooing, and the absence of it is ground for suspicion of something other than suicide : murder, or, of course, accidental shooting.

I hope I have given you some idea of your duties when you are called to examine a body found dead. *It is not one of my duties to teach you how to dispose of a body* quietly and without fuss, but you may have inferred how from what I have not said.

"Take Your Medicine"

A REVUE demands three things at least—topicality, continuity and polish. It must never drag ; the audience must never be bored. If, to some unfortunate person, the sound of a piano is the prelude to nausea, comfort should be found in the fact that the pianist has curly black hair and the appealing eyes of a young man who wants to sell a vacuum-cleaner. To present a revue, therefore, is no easy matter. "Take Your Medicine" was undoubtedly good entertainment ; and that it came near, on the last night, to being a good revue as well says a very great deal in its favour.

It is hard to criticise the quality of the items because there is no real standard by which to judge them, but there are several things which linger pleasantly in the memory. Never was so much owed by so many to Miss Few. When she sang "I'll See You Again" with such exquisite charm, we sincerely hoped that she meant it.

We expected something good from Michael Hall and he did not fail us. A new song from this accomplished artist is always a delight, and how easily do we forget the antiquated piano. Peter Barrett gave us some rare touches of humour. He was never better than when he waxed lyrical over the sentimentality of the hour—the impassive face, the pseudo-emotional voice, the delicious anti-climax. David Oriel and Graham Blewett wrote the bulk of the script and had their supreme moments. They appeared many times and amused us on practically every occasion.

Of the sketches, the one gently satirising the X-Ray Department was, perhaps, the best. It was topical ; it was successful. The same applies to the shortened, melodramatic version of the recent production of "Rope." Here was madness indeed. The three leading characters in the play were brilliantly caricatured. There was much subtlety in Tom Madden's conception of the ballet—a most original item. Alan McCallum proved that the rugger field is not the only medium for artistic talent ; Biddy Taylor was even more alluring than ever ; and from Wales we had a large contribution. The remaining ingredients were too numerous to mention.

The enthusiasm of the audience was sufficient proof of an adequate evening. Our thanks are due to those responsible for the production. They have good reason to be satisfied and should have gained something in experience. There is a tendency in amateur shows of this nature to attempt too much. It is an atmosphere of well-conceived restraint, rather than any superfluous and reprehensible embellishment, which imparts that agreeable flavour to the better West End Revues. R.H.N.L.

Correspondence

CLUBS' UNION.

To the Editor of the GAZETTE.

SIR,—In your issue of April 28th, 1945, you published a letter over the names of six signatories which suggested that the Clubs' Union should be altered and enlarged to include in its membership not only the medical and dental students of the Hospital, but also every nurse, massage, electrical and radiological student. Here the line was rather arbitrarily drawn.

No one doubts that the time has come for the constitution of the Clubs' Union to be reviewed and for changes to be made. There is reason to believe that this may be soon. But it is of the first importance that certain observations be borne in mind.

Primarily, Guy's is a great medical and dental school, and on that its world-wide reputation has been made. The medical and dental students are the backbone of that continuing tradition and the Clubs' Union is theirs and should remain so. It may be pointed out that the assets of the Clubs' Union are the subscriptions and donations of generations of past students, and in that respect are a trust in their names not gratuitously to be used for those who have no claim to them.

Now this is not to say that the Clubs' Union cannot do even more than it has already done to assist in the provision of recreational facilities for the nurses and *ancillary* students; for example, in the loan of rooms, grounds or equipment. It is not to say that because the Dramatic Society and Musical Society have women members thay they must not be helped financially if this seems called for. But it is essential that the Clubs' Union should remain the corporate body of the great company upon which the Hospital depends for its fame—the medical and dental students which it trains. By all means let it generously help others who work at Guy's and thus, perhaps, encourage them to help themselves.

Your correspondents talk much about "cultural activities." They appear to imagine that the acquisition of culture depends on living in a large organised holiday camp for which their letter reads not unlike a prospectus. It is a fact, however, that those who work in hospitals have too little contact with the outside world and that in time of war this isolation is aggravated. Had your correspondents had their student days in peace-time they would realise that there are ways of broadening the mind in London without continually "getting together," as they put it, each with the other.

Lastly, the time is not propitious to act upon the agitation of those who do not know the Guy's of peace. The views of the post-war generation must weigh heavily, the views of those who, although contemporaries of your correspondents, have seen fit to defer their medical education until their service in the forces is completed.

Yours, etc.,

R. T. HINDE.

42, Trinity Church Square, S.E.1.

CLUBS' UNION.

To the Editor of the GAZETTE.

SIR,—May I, as one of the signatories to the letter *re* the Clubs' Union in *Gazette* (1481) be allowed to comment upon the remarks in "Passim" in your last issue? I have been too long at Guy's to be more than usually surprised at the absence of letters in answer, but I believe that in this case the silence does in fact mean the consent of what my enquiries would indicate to be the large majority of students.

It may be of interest to your readers to know that the letter was discussed at a meeting of officers and members of all but four of the clubs and societies of the Clubs' Union, and a resolution, passed unanimously, was forwarded to the Council asking them to amend the rules to allow clubs wishing to admit women to retain their affiliation to the Clubs' Union.

This is just the first step, revolutionary perhaps, leading to the gradual evolution of efficient recreational facilities for *all* students at Guy's. At what point evolution becomes revolution is debatable, but the "organised social structure" which fills the editorial heart with horror is no more than the happy and efficient arrangements for recreation found in the well-run provincial university union.

As for "damping the ardour of youth," may I mention that the prime instigator of this "revolutionary" letter has been at Guy's as long as any other student here; that, in fact, the medical and dental signatories are all senior clinical students; and that the others are also all seniors in their respective branches?

The remark "that people are too apt to destroy an old system" seems to suggest that we wish to destroy the Clubs' Union. Nothing could be further from the truth. This is so much a part of Guy's and such a well-established organisation that it would be fatal to scrap it or to fail to use it as a basis for the improvements we desire.

The question of the *Gazette* office involves larger issues than can be discussed here, but—the *Gazette* is a constituent part of the Clubs' Union and, presumably, its official organ. However, it has two conflicting objectives—(*a*) to be a house magazine for the Hospital, (*b*) to maintain its reputation as a world-wide scientific journal and link with old Guy's men. Criticism of the *Gazette* often forgets the circulation radio of (*a*) to (*b*)—*i.e.*, about 800–2,200. I cannot suggest solutions to the problem here, but the signatories obviously had their minds on the Clubs' Union constitution and the objective (*a*) above.

Yours, etc.,

G. A. MORRANT.

[The *Gazette* is not the official organ of any Union, it is a Journal of Medicine, Surgery, Dentistry and Hospital news—also the *Gazette* has no representation on the Clubs' Union Council.—ED.]

ANOTHER LETTER FROM BELSEN.

To the Editor of the GAZETTE.

SIR,—This second letter from Belsen is, like the first, somewhat delayed and will probably arrive in England after we have returned to Guy's.

Belsen concentration camp is fast disappearing and to-morrow (Monday, May 21st, 1945) there is to be a ceremonial destruction of the last hut, a function to which everyone here is cordially invited. For the past few days the Army has been burning block after block—much to the delight of the remaining inhabitants of the camp. All the sick and the fit have now been evacuated to more pleasant quarters in the area in which we live—the former to the hospitals and the latter to some of the S.S. blocks.

Thus it is that our work has gradually moved to more acceptable conditions which, although far from ideal, are at least conducive to some medical treatment. The patients have been cleaned and are receiving, as far as possible, the necessary diets; much experimental work is being carried out with the protein hydrolysate, given orally and intravenously, and also with plasma and serum transfusions. So far, in contradiction to any previous statement about hydrolysate, results with this food have not been generally encouraging and twice-concentrated plasma seems to be gaining popularity. In many cases famine œdema has been found to respond to plasma and not to hydrolysate transfusion. Statistics, when available, should be interesting, and I am sorry that I am unable to let you have any figures at present.

The diarrhœa is definitely on the wane, thanks, it would seem, largely to sulphathiazole and not to tanallin.

A rather distressing situation is the lack of treatment for the many cases of pulmonary tuberculosis. Even X-rays are at a minimum, the German hospital nearby, where we also treat patients, being able to take only twenty X-ray pictures per day owing to shortage of supplies.

It is interesting to note how the psychology acquired by the internees during their imprisonment persists with most of them even now—that is to say, it is still a question of every man for himself. One person will take as much food as he can, regardless of the more urgent needs of his sick neighbour. Dishonesty is prevalent and we have to keep a wary eye on our personal possessions lest any inquisitive internee should choose to "liberate" them. Let us hope that their virtues will return with their health!

We have had the advantage of several talks from some of the medical personnel out here. Brigadier Hughes, Senior Medical Officer to the 2nd Army, told us of conditions here at the time of the liberation of the camp and also informed us of some of the latest world events, a very welcome discourse as we are very much isolated from news. Dame Janet Vaughan spoke on the use, advantages and disadvantages of protein hydrolysate; and Colonel Lipscombe, Medical Adviser to Belsen Camp, delivered a lecture on typhus.

We have just had news of the recent hospital *coup de force* and trust that Guy's remained triumphant to the end.

Yours, etc.,

DENNIS M. FORSDICK.

British Red Cross Commission,
H.Q. 5, Civilian Relief (Students), B.L.A.

Sport and Hospital Information, etc.

Cricket

GUY'S *v.* OVERSEAS H.Q. R.A.A.F.

(*Played at H.O.P. on Saturday, May 12th.*)

Result: Lost. Scores: Guy's 95; R.A.A.F. 96 for four wickets.

Guy's opened their season with a match against the Australian Air Force. Winning the toss Guy's decided to bat on a perfect wicket in brilliant sunshine. In a very few minutes the opening pair had returned to the pavilion. Worse was to come, for at the fall of the fourth wicket only fifteen runs were on the board. However, Garland and Evans prevented a complete collapse, Evans scoring a bright 22 in a few minutes. Garland, playing resolute cricket, was the last wicket to fall, having scored a useful 39, a promising start for a newcomer to the side. The only other member of the side to make any impression was Webb—undefeated, with 10 to his credit. Guy's were dismissed for 95 runs.

The Australians opened confidently, and it was not until 60 was reached that a wicket fell. With four wickets down the Hospital's total was passed.

Team.—L. D. Carton Kelly, E. W. Graham, D. J. Sheerboom, A. E. Trist, W. B. Webb, J. D. Williams, I. L. Busbridge, W. A. Evans, G. P. Billingham, D. P. Nicholson, W. H. Garland.

GUY'S *v.* GUILDFORD C.C.

(*Played at Guildford on Saturday on May 19th.*)

Result: Draw. Score: Guildford, 171 for nine wickets dec.; Guy's, 160 for seven wickets.

Playing against Guildford, a strong club side, Guy's won the toss and elected to field. The wisdom of this decision was soon to be disproved, when the opening pair, Moss and McNulty, put 92 runs on the board in the first hour. The rate of scoring was, however, reduced when the medium and slow bowlers replaced the fast.

At 129 the first wicket fell, Webb getting Moss caught for 66, the next man being dismissed with the following delivery. Webb then removed McNulty for 56, and he with Carton-Kelly and Evans contrived to dismiss all but one of the remaining batsmen for a further addition of only 42 runs. Guildford then declared at 171 for nine wickets, Webb's five wickets for 41 being excellent figures for so plum a wicket.

The Guy's innings started anything but favourably, Billingham reurning for 5, having shown us one delightful boundary stroke. At 25 the pavilion received Graham, who made a brisk 16 before falling victim to the vigilance of second slip. Garland and Evans had no success, and at 28 for four wickets Munro joined Williams, who till now had been ill at ease with the slow bowlers, and it was they who were to change the whole aspect of the game. Between them they brought the score to 135—a fourth wicket stand of 107—treating fast and slow blowers alike. Williams played delightful cricket, showing stronger driving and cutting power than we have hitherto seen and Munro produced first-class form and a pleasing degree of aggression lost since his earlier games for the side two and three years ago. They both reached their fifties about the same time, and at a quarter past seven we needed forty runs to win and a quarter of an hour in which to get them. In attempting this Munro was caught for 54 and the Hospital lost two further wickets. At the close of play we were 11 runs behind, with Williams still at the wicket, undefeated for 66. This indeed was a good game and augurs well for the coming matches.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, I. A. H. Munro, J. D. Williams, W. B. Webb, I. L. Busbridge, W. A. Evans, G. P. Billingham, W. H. Garland, J. B. Parsons.

Change of Address

A. W. Banks (336145), Lt., R.A.M.C., Depot and T.E. E.A.M.M.C., E. Africa Command.

J. R. Forbes, Surg.-Lt. Cmdr., R.N.V.R., H.M.S. *Maine*, c/o G.P.O., London.

A. B. Lee, Surg.-Lt., R.N.V.R., H.M.S. *Quilliam*, c/o G.P.O., London.

P. H. Staple (61880), Ft.-Lt., R.A.F., 910 Wing, R.A.F., S.E.A.A.F.

Paul Davies, Sqd.-Ldr. R.A.F.(V.R.), Glynafon, Newcastle Emlyn, S. Wales.

Theodore Brocklehurst, M.R.C.S., Clavering, Cooden, Bexhill-on-Sea.

E. A. Starling, M.Ch., and E. C. W. Starling, M.C., M.R.C.S., 2, The Royal Chase, Mt. Ephraim, Tunbridge Wells.

A. W. P. Stone (127075), Sqd.-Ldr., R.A.F., R.A.F. Medical Unit, S.E. Asia Air Force.

Joan Widlake, P/342638 Q.A.I.M.N.S.R., R.F.R.O.A., India Command.

Marriages

WILLIAMS—CROSBIE.—On April 21st, 1945, at St. George's Cathedral, Jerusalem, by the Anglican Bishop in Jerusalem, Gordon Lewis Mount Williams, Surg.Lt.-(D.), R.N.V.R., son of the late Mr. Gordon Williams and Mrs. Williams, Kingston-on-Thames, to Patricia Lorelle Crosbie, daughter of Mr. and Mrs. R. E. H. Crosbie, Jerusalem.

DAVIES—CRADOCK.—On May 1st, 1945, at Khorramshahr, South Iran, Eric Ralph Davies, F.R.C.S., to Pamela Alleyne Cradock, S.R.N.

BARLOW—LINGS.—On April 21st, 1945, at Bolton, Lancs, Frank Ewen Barlow (Capt., A.D. Corps) to Joyce Anderton Lings.

DAVIES—BISHOP,—On May 10th, 1945, at *All Saints' Cathedral, Cairo, Paul Davies*, Sqd.-Ldr., R.A.F.V.R., to Helen Macdonald Bishop, P.M.R.A.F.N.S.

GILFORD—DOWLAND.—On May 14th, 1945, at Erdington Parish Church, George H. Gilfor,d M.B. (Lond.), to Irene M. Dowland, S.R.N.

Deaths

DRURY.—On May 7th, 1945, at Colombo, John W. Drury, Surg.-Lt. (D.), R.N.V.R., aged twenty-six years, only son of Mr. and Mrs. Frank Drury, of Dulwich.

KNAGGS.—On April 16th, 1945, Robert Lawford Knaggs, M.A., M.D., F.R.C.S., 20, Forde Park, Newton Abbot, Devon.

PANTING.—On May 4th, 1945, Laurence Christopher Panting, M.A., M.D., M.B., B.Ch., F.R.C.S., Truro, Cornwall.

SELLS.—On May 8th, 1945, at Northfleet, Hubert Thomas Sells, M.R.C.S., aged eighty-six.

WILLIAMS.—On May 10th, 1945, from injuries abroad, John Norman Williams, S/Ldr., R.A.F., only son of Mr. and Mrs. M. T. Williams, of Ardwyn, Abersoch.

SHARPE.—On May 7th, 1945, suddenly, Herbert Sharpe, B.A., M.R.C.S., twenty-one years Medical Superintendent, Ware Park Sanatorium, Herts.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1485 *23rd June, 1945* *Ninepence*

PASSIM

VISCOUNT NUFFIELD needs no introduction to Guy's men and women, for his name is ineradicably linked with that of our founder and first benefactor. There may be some, however, who do not appreciate the full extent of Lord Nuffield's munificence towards the Hospital—some who do not know that in addition to his many other gifts, he provided the funds for the building of Nuffield House and for the building of the new Nurses' Home. In addition to this he purchased for the Hospital the land on which the York Clinic now stands. But Lord Nuffield's interest in the Hospital is not solely confined to the provision of finances; as President, he takes a lively interest in Hospital affairs and attends our functions with a regularity which is surprising, considering his extensive commitments elsewhere.

Shortly before his death, the late Sir Arthur Hurst proposed that a statue should be erected to commemorate the many benefactions that Guy's has received from Lord Nuffield; this suggestion was unanimously approved by the Court of Governors. It is thought that such a statue, of the same nature as that of the Founder, would be the most fitting tribute that we could pay to his generosity.

The estimated cost of the statue has been put at £2,500, and it is thought that everyone connected with, or who is interested in, Guy's would wish to contribute towards it. Donations should be sent to the Clerk to the Governors.

The work on the wards in Guy's House goes on apace, and it is thought that four of these will be ready to receive patients by the end of the year. To bridge the gap from now until December, we are fortunate in being able to retain the use of the Wildernesse at Seal. The original arrangement was that we should cease to occupy it three months after the end of hostilities in Europe. Owing to the generosity of Mr. George Fawcett, the owner, however, we have now been granted this extension. The rental during the occupation has been one shilling per annum.

During the years of the war in Europe, circumstance elected that we should have relatively few cases in Guy's and that the majority of chronically ill or convalescent patients should be evacuated to base hospitals in Kent. Though this has thrown a strain on the teaching facilities at Guy's, it has been in many ways a successful arrangement. It seems eminently desirable that patients, who are in the stages of recovery from some acute illness, should be able to do this in the country. From a purely practical point of view, they are, in most cases, no longer valuable as teaching cases and, from the therapeutic aspect, their health is more likely to benefit from the country air than from that of the Borough and their convalescence from the pleasant surroundings.

Consequently the news that a property has been purchased on behalf of the Hospital for the provision of a permanent Home for after-treatment is a welcome surprise. The house is known as Holmesdale and is situated near Redhill in Surrey, and the estate comprises some forty-six acres; it is proposed that the house be adapted for Staff accommodation and that a Hospital or Home of Recovery be built in the grounds with accommodation for about two hundred and fifty beds. The entire cost of purchasing this property has been met by Mr. W. H. McAlpine and by Mr. S. B. Askew, one of our Governors.

IN this issue we are publishing another photograph of the Queen's visit; it is unfortunate that we have only lately come in possession of this, but we feel that, in spite of its lateness, it will be appreciated by Guy's men away from the Hospital.

WE would like to congratulate Sister Wittrick on her award, M.B.E., in the Birthday Honours.

WE congratulate Mr. Southcombe on his appointment as Head Porter in the Front Lodge.

Thyrotoxicosis in Relation to Ophthalmology

A Clinical Lecture by O. G. MORGAN, M.Ch., F.R.C.S.

GENTLEMEN,—This lecture is based on a discussion held at the Ophthalmological Congress of 1943, when papers were read by Russell Brain, Sadin, Mulvany and others, and I thought you would be interested in hearing some of their theories on a subject which is admittedly complex and in which, unfortunately, it must be said that whatever one's views are to-day they will probably be quite different in six months' time! It would appear that most subjects start by appearing to be simple—then they become almost impossibly complex—before some genius comes along and reduces the whole mass of material to its ultimate simplicity again. This latter stage has not yet been reached in the subject under discussion.

Originally exophthalmic goitre was thought to be equivalent to hyperthyroidism, and ophthalmoplegia was "Ballet's" sign in exophthalmic goitre. Now it is obvious that this was much too simple. The hyperthyroid state comprises about a dozen clinical varieties which fall into three main groups:—

(*a*) Thyrotrophic hyperthyroidism, depending on pituitary control, exemplified by exophthalmic ophthalmoplegia;

(*b*) Thyrotoxicosis, exemplified by Graves' disease;

(*c*) Thyropathic hyperthyroidism, found in some cases of neoplasm, inflammation and lymphadenoid goitre.

The difference between (*a*) and (*b*) is complete in ætiology, pathology, symptomatology and effects of treatment and, more important still, the thyrotrophic hormone is present in increased amounts in the blood in (*a*) and not in (*b*).

Many attempts have been made to find an increased percentage in cases of Graves' disease, but without success; but it has been found in all cases of (*a*) whether this is accompanied by hyperthyroidism or myxœdema.

Let us consider the main symptoms found in this group of cases and see how they fit in and interact:—

Exophthalmos.—It is well known that exophthalmos may be slight or absent in thyrotoxicosis due to thyroid adenoma, whereas the grossest exophthalmos is found associated with myxœdema following thyroidectomy. Exophthalmos may be found with excessive normal or diminished thyroid secretion.

State of Thyroid.	*Exophthalmic Syndrome.*
Hyperthyroidism	Exophthalmic goitre. Exophthalmic ophthalmoplegia (some cases). Acromegaly (some cases).
Normal	Exophthalmic ophthalmoplegia (some cases).
Hypothyroidism	Post-operative exopthalmic ophthalmoplegia. Spontaneous myxœdema (rare). Acromegaly (rare).

There is, therefore, some other controlling secretion, and this is probably the thyrotrophic hormone of the pituitary, and it is also probable that the thyroid-pituitary relationship is a self-limiting one under normal conditions. The pituitary stimulates the thyroid to secret thyroxin, which itself then acts as a brake on the production of the thyrotrophic hormone. This would explain the phenomenon that exophthalmos is more readily produced by injection of the hormone in thyroidectomised guinea-pigs than in normal ones and also the exophthalmos in post-operative thyroidectomy.

The exact orbital changes in exophthalmos are still a little obscure, but it is certainly quite different in the two main groups.

In thyrotoxic cases there are two elements: one due to stimulation of the unstriped muscle fibres in the upper and lower lids which, in contraction, tend to produce a forward movement of the eyeball, and a second due to the wasting and degeneration of the voluntary muscles. It is probably this myasthenia which allows the exophthalmos to take place.

In thyrotrophic cases the exophthalmos is due to an actual increase in bulk of the orbital contents, resulting in increased pressure in the orbit behind the globe. The muscles may be enormously increased in girth by œdema, fibrosis, degeneration, and round-cell infiltration.

The exophthalmos in thyrotoxic cases can be cured or improved by thyroidectomy. In thyrotrophic cases it can never be so and, in fact, it may be increased after the removal of the thyroid.

Lid Retraction.—In thyrotoxicosis this is due in the main to spasm of the unstriped muscle fibres. In thyrotrophic cases it results from the inability of the lids to cover the proptosed eyeball.

Retro-bulbar Pressure.—Not present in classical Graves' disease, but constant in thyrotrophic cases.

Congestion and œdema absent in Graves' disease, but it appears early in thyrotrophic cases and shows itself as a glistening appearance of the conjunctiva, which increases to chemosis and later takes its part in the production of corneal ulceration.

Lid suture is useful in thyrotoxic cases and may tide over the period when the cornea is exposed before the operation of thyroidectomy causes it to subside. In thyrotrophic cases it is usually useless, as the retro-ocular pressure is irresistible and lid suture only increases this pressure. Orbital decompression by removal of the roof and lateral walls of the orbit is the only possible method of saving the cornea in these malignant cases.

Disturbance of Ocular Muscle Balance.—In Graves' disease this is the result of unequal development of the myotonia in the voluntary muscles. Transient diplopias are common both before and after thyroidectomy. It is noticeable that these diplopias improve after rest and they respond to the action of prostigmine.

In thyrotrophic cases the muscle pareses are due to unequal degeneration in the ocular muscles and are more permanent. Elevation is the movement most commonly affected in the early stages.

Dislocation of the globe is found in Graves' disease when the lids are very much retracted by spasm. It is not seen in thyrotrophic conditions.

Basal metabolism is persistently high in thyrotoxicosis, while the exophthalmos is increasing. In thyrotrophic cases it is usually high at some period of the disease, but may be high, low or normal with increasing proptosis.

Iodine therapy is beneficial in thyrotoxicosis and may be so in thyrotrophic conditions also, as it tends to reduce the formation of thyrotrophic hormone as well as of thyroxin.

In thyrotrophic cases other methods of treatment which act on the pituitary have been found useful. Thyurosil-ovarian follicular hormone and testosterone propionate and also deep X-rays have all been tried with some success.

A few other points of ophthalmic interest may be mentioned.

In operations for thyroidectomy great care should be taken to prevent damage to the cornea. Premedication, no struggling by the patient, no touching of the cornea and a drop of parolein oil will all help. Cataract may develop after thyroidectomy, and this is probably due to the development of post-operative tetany. Calcium and parathyroid have kept this under control.

Arterial pulsation may be noted in the retinal artery due to the impulse from the very violently beating heart. It is only found otherwise in glaucoma when the intra-ocular pressure is greater than the diastolic pressure in the retinal artery, and in extreme degrees of vascular sclerosis where the impulse is not absorbed by the resilience of the artery, but passes up the hard vessel and can be seen with the ophthalmoscope.

Papilloedema may occur in thyrotrophic cases as a result of the high pressure behind the globe.

Other signs which are associated with the names of distinguished observers and which have, therefore, a sentimental as well as a scientific interest are :—

Signs due to muscular inco-ordination.	Infrequent blinking.
	Lagging of upper lid on looking down.
	Upper lid follows eye downwards in jumps.
	Trembling of closed lids.
	Insufficiency of convergence.
Plain muscle signs	Retraction of upper lid.
	Lower lid raised over cornea when upper is retracted.
Exophthalmos	Absent creases in forehead when looking upward.
	Easy subluxation of globe.
	Difficult eversion of upper lid.
Unclassified	Pigmentation of upper lids.

A Case of Dermato-Myositis

By R. O. BARBER, L.R.C.P., M.R.C.S., L.D.S.

THIS patient, a female aged seventy-five, was transferred from London on August 15th, 1944, with a diagnosis of paralysis agitans and had had a fracture of the right femur in March, 1943. No previous history was available.

On examination she was a feeble, emaciated, bedridden old person with the typical appearances—of mask-like face; slow monotonous speech; flexion of the body; coarse tremors and pill-rolling movements.

No therapeutic measures appeared to be indicated until September 15th, 1944, when an intense pruritus developed—disappearing two days later to reappear after five weeks, when it was seen to be urticarial in nature—over the arms, shoulders and abdomen. She came under my care on October 25th, 1944, when the skin was observed to have the ichthyotic appearance of senility, dry and scaly, with atrophied hair and nails with many excoriations due to pruritus senilis, which later became and remained intense. A definite diagnosis was not possible; however, during the next ten weeks an empirical attempt was made to alleviate the condition by giving a cotton night-dress to wear, various lotions and applications locally, all of which had but a transient effect; the skin condition gradually became worse. Calcium lactate, yeast tablets and phenobarbitone were also given with fair success, the skin lesion changing from urticarial to eczematous nature.

On December 3rd, 1944, subcutaneous œdema became apparent and the skin was very much thickened and even more scaly; and, on December 20th, 1944, a small swelling appeared at the insertion of the left triceps which lasted three days. The patient then complained of pain in the shoulders, elbows and knees and the skin condition had become a generalised weeping, eczematous type with hyperidrosis; on Boxing Day swellings appeared again in left elbow and, in addition, both shoulders in the region of the insertion of the trapeziei; these enlarged until, by January 2nd, 1945, definite "lumps" had developed, not attached to skin but attached to underlying fascia, not tender, and about 3 in. by 3½ in., all joints painful on movement. The patient also developed basal rhonchi and a cough, became incontinent and restless, and complained of pain in her left chest and her legs became very œdematous.

A diagnosis of dermatomyositis was made (January 5th, 1945); on January 18th the right elbow became involved and an attempt was made to obtain diuresis; also marmite was added to the diet (no Vitamin B tablets available). The left knee began to swell along the insertion of semi-tendinosus and the patient deteriorated and signs of broncho-pneumonia developed. She died on January 30th, 1945, the temperature never rising above 98.4.

Laboratory Investigation.—W.R. was negative.

Blood Picture.—Erythrocytes, 4.400,000 (15/1/45); hæmoglobin, 80 per cent.; C.I., 0.9; leucocytes, 22,000; polymorph., 85 per cent.; lymphocytes, 10 per cent.; eosinophils, 4.5 per cent. Blood uric acid not done.

Dermatomyositis is a well-recognised syndrome, stated (Price) to be an acute or subacute inflammation of the muscles of unknown origin associated with dermatitis and œdema; in this instance the dermatitis was well established before the myositis and the œdema occurred as a constant feature.

What exactly is the pathology? Dowling (*Lancet*, 1939, I, 1424) has suggested it is similar to generalised scleroderma, which is a disease of young adult females chiefly, with stiffness of joints, and the skin appearing swollen and glossy and very hard, which was not so in the case under discussion.

Can it be a manifestation of Vitamin B 2 deficiency? Many of the senile patients on admittance to hospital exhibit gross hypovitaminosis and their vitamin requirements are much higher than with young adults.

In keeping with the general care of these patients only the minimum investigation are performed, every endeavour being made to keep them interested in the communal life of the ward.

Queen's Visit

Photo by L. A. Rees

Reviews

Battle for Health. A Primer of Social Medicine. By STEPHEN TAYLOR, M.D., M.R.C.P. Published by Nicholson & Watson. Pp. 128. *Price 5s.*

STRICTLY speaking, this book is for the intelligent layman, but, as the subsidiary title implies, medical students should find it very interesting and stimulating.

The theme of the book is the presentation of the idea of disease in terms of war. The battlefield is reviewed, the enemy examined and our forces surveyed. The emphasis is laid not so much on the immediate work of the Army—that is, the doctors—but on the planning and the right use of knowledge and economic factors to prevent the disaster of war—*i.e.*, disease. We are shown what the intelligent layman can do towards the solution of this problem by his understanding of the disease factors which are so closely related to poverty, ignorance and fear, and which he himself can help to control.

As Dr. Taylor points out in his prefatory note, his aim has been to provide the reader with the facts and then the conclusions to be drawn from them. Many of his facts are presented in the form of iso-type charts, each of which demands careful scrutiny and therefore tends to the avoidance of false conclusions.

Dr. Taylor does not forget the important part played by the ancillary health services, the district nurses, the almoners, the sanitary inspectors and welfare workers towards the maintenance of a healthy nation.

The text is profusely illustrated with photographs in the "Lilliput" contrast style (Incidentally, there is an interesting comparison between Guy's and the New York Hospital.)

Dr. Taylor also shows by figures on the response to the diphtheria and V.D. cam-

paigns, how important a part health education can play in combating disease. In his concluding chapters he comes out strongly in his advocacy of a planned medical service.

J. P. M. B.

A Text-book of Psychiatry. By D. K. HENDERSON, M.D. (Ed.), F.R.C.P. (Ed.), and R. D. GILLESPIE, M.D.(Glas.), F.R.C.P., D.P.M. Sixth editilon. Published by Oxford University Press. Pp. 732. *Price* 25*s*.

PSYCHOLOGICAL medicine still tends to be regarded among students as a necessary evil in the medical curriculum, and the apparent lack of scientific precision and the confusion of terminology lend colour to that view. It has always been the aim of the authors of this book to dispel that idea by avoiding the use of technical terms whenever possible and by trying to show how closely related is psychiatry with our everyday work in the hospital. (Indeed, as Dr. Gillespie has pointed out in his lectures here, one-sixth of all the out-patients attending Guy's have some psychiatric disturbance.)

In keeping with their original intentions, one of the chief changes which the authors have made in this edition is the promotion of the psycho-neurotic reaction types to a place of prominence; so impressed are they with its importance.

A new chapter has been devoted to methods of physical treatment, the so-called "triumphs of empiricism." The chapter on war psychiatry has naturally been retained and considerably enlarged and throughout the book increasing stress has been laid on the social aspects of psychiatry. The practice of including fairly detailed case-histories contributes at once both to the interest of the book and the reality of the subject. Indeed, the subject is well served from every aspect in this book, avoiding, as it does, unnecessary concern with the various "schools" of psychiatry, although if the authors were to be accused of bias towards any particular school, it would be towards Adolf Meyer and his followers.

J. P. M. B.

Correspondence

A LETTER FROM MR. T. B. LAYTON.

To the Editor of the GAZETTE.

SIR,—I have received the following letter from Mr. Layton, who has suggested that readers of the *Gazette* might be interested in its publication. A photograph of Garibaldi in full uniform, sword in hand, with the clothing removed to display his ulcerated right ankle was included with the letter and will be mounted with it in the historical section of the Gordon Museum.

"My dear Keith Simpson,—You know, I suppose, that we have the original Nelaton's probe in the Museum. But do you know the story of Garibaldi's wound? This is as I had it years ago from Mr. Haslam, of Birmingham, who examined me in Operative Surgery in the Final Fellowship. He was very interested in the history of surgical instruments and used to show Nelaton's probe to anyone who was so good that obviously he was through in the first half of the viva.

"Garibaldi had a wound of the ankle that would not heal and developed a callous ulcer all around the opening of a sinus. The Italian surgeons thought there was a dead bit of bone, but they had down Nelaton from Paris, who probed it and said 'No!' He could tell by the feel that the bullet was still there and it was that and not dead bone that was preventing healing. The Italian surgeons were not convinced and Nelaton returned to Paris. There he had his probe made with a bit of asbestos on the end and sent it to Italy, telling them to probe the wound with it and then to scrape off what was adhering to the asbestos and to test it chemically for lead. They did so and found the lead, proving that Nelaton was right.

"I think this is all evidence of the extraordinary development of the sense of feel the old surgeons of the pre-aseptic days must have had. Nelaton gave the probe to Sir James Paget. He gave it to Dr. Cock (I think F. W.), also dead, over ninety since the beginning of the War and who was an old Guy's man and an anæsthetist at Bart.'s (? at Guy's as well). He used to send me a patient every

few years from right down in Cornwall, where he had retired—the last only just before the War. Now Dr. Cock was one of the first people who got interested in the history of surgical instruments (hence Paget's gift) and, when he retired, he gave half of his collection to Guy's and half to Bart.'s and the Nelaton probe was in the Guy's half.

"There is, of course, one snag in this story. Why did the Italian surgeons send the probe back to Nelaton after they had found the lead? Or did Nelaton have one or more duplicates made and was it one of these he gave Paget? However, until the contrary is proven we will stick to the story at Guy's.

"Now for my photo which I send you for the Museum. No doubt about it being Garibaldi. There is the ugly wound of the ankle with its callous edge smoothing off a bit in old age. I saw a larger copy of this in a shop in Palermo, marked 'Not for sale,' but I went in and asked them about it; when it was taken, etc. They did not know. The original had been brought in by a customer who had asked them to make a copy. They could not sell the one in the window, but they kept the negative and could make some more, so I ordered three and send you one of them.

"Yours ever,

"T. B. LAYTON."

I feel that this kind of letter has itself an interest which will grow with time, and that any of us who receive such interesting correspondence would do well to have it preserved. The value of original correspondence is all too frequently overlooked at the time it is received.

I am, etc.,

KEITH SIMPSON.

Gordon Museum,
Guy's Hospital, S.E.1.

PRAISE FOR THE NURSING SERVICES.

To the Editor of the GAZETTE.

SIR,—The war in Europe has ended and, in the flush of victory, praises have been sung to all who played their part, and not least to those nursing services which have accompanied the fighting men on every battle front. Little, however, has been written of the nursing staffs of the London hospitals or any civilian hospital which now bears the scars of battle. In these places the nurses have stood fast and maintained their long hours of work and their high efficiency in spite of extra shifts and loss of sleep, looking ahead the while to the better and broader-minded world of peace.

Now that hospital authorities are anticipating re-openings and expansions, it would be a pity to forget what the nursing services have done for us during the last six years. The enlarged hospital system of the future will need many more nurses to run their wards. Nurses are already in short supply, and how shall these numbers be made up if the prospect before them, on entering the profession, is not made more attractive?

Now is the time to remember their long hours of work, their low salary and the responsibilities with which even the relatively junior nurses are entrusted while on duty, and the rules and regulations to which they must submit when off duty.

At a certain London hospital which comes readily to mind the student nurses on night duty from 9 p.m. until 8 a.m. get up twice a week at 5 p.m. (the equivalent of 5 a.m. to those who work by day) to attend a class from 5.30 p.m. to 6.30 p.m. with their breakfast (like so many of their meals, not always hot, not always palatable, not always sufficient perhaps) not until 8 p.m.—two and a half hours after they were wakened. It is not unknown for such a class to be cancelled fifteen minutes after it was due to commence.

Many nurses are over twenty-one, some even before they enter the profession; little wonder that they find such restrictions rather irksome.

If the time has come to put nursing in the same rank as other professions, would it not be well to remember that "a little help is worth a deal of pity," and when the nurses come to ask that their conditions off duty as well as on duty should be improved, may their requests be considered generously.

Yours, etc.,

"PERSEUS."

Medical School, Guy's Hospital, S.E.1.

A TRIBUTE TO SISTER GALE.

To the Editor of the GAZETTE.

SIR,—May I, on behalf of many generations of Guy's nurses, pay some small tribute to Sister Gale as a ward sister? A number of years ago, as a junior probationer, I worked under her in "Cornelius," and even at that early stage of my career, was greatly impressed by her extreme efficiency—never the cold type of efficiency—but always tempered with great kindliness and a lively sense of humour. No matter what happened, the patient always came first.

Later on I learnt to value her even blending of good nursing, good administration and good teaching—all so essential in a ward sister. I am sure that there are many of us who feel we owe her a great debt of gratitude, and shall always have the happiest memories of working with her. We wish her all the good things she deserves in her retirement.

Yours, etc.,

EVELYN A. OPIE.

Guy's Hospital, S.E.1.

FRONT SURGERY CARDS.

To the Editor of the GAZETTE.

SIR,—All students who hold the appointment of senior dresser greatly appreciate any comments made by the Hospital clinicians on the cases seen by them in Front Surgery and referred to their departments for diagnosis and treatment.

Unfortunately, of late, many of the Front Surgery cards are returned without these valuable comments. From the Dental Department these cards are never returned. This is no doubt due to the war-time shortage of Hospital staff, resulting in the increase amount of work for those remaining.

May I suggest, therefore, that those students who, in Out-patients' departments, see these referred Front Surgery cases with the clinicians, write a short *precis* of any remarks made during the examination. This would be no irksome task for our colleagues attending these clinics and would greatly enhance the value of the senior dresser appointment.

Yours, etc.,

Guy's Hospital, S.E.1. DENIS DENNISON.

WOMEN MEDICAL STUDENTS.

To the Editor of the GAZETTE.

SIR,—I entirely agree with your remarks in "Passim" concerning the admittance of women medical students to Guy's. I cannot think why they should not be admitted, but what is going to happen to the term "Guy's man"? Let there be some preserves kept inviolate from the inroads of the female sex, and yet I see it is too late; women are already studying at the Hospital, the fifth column is within its walls, and the citadel will surely fall.

Yours, etc.,

D. W. MAYMAN, Capt., R.A.M.C.

R.A.M.C. Mess, Rawalpindi, India.

CLUBS' UNION.

To the Editor of the GAZETTE.

SIR,—In another of his characteristic and forthright letters your correspondent, R. T. Hinde, makes the astounding statement that the reputation of Guy's rests upon the medical and dental students therein. This is a palpable insult to the nursing and auxiliary staffs, and one from which all clear-thinking men will wish to dissociate themselves.

All hospitals ultimately depend upon the cheerful co-operation of their entire staffs, and the blending of social and other interests cannot be but for the good of all.

Mr. Hinde, it seems, is prepared to offer a few crumbs from his table to others, but is too hide-bound by tradition and prejudice to take the bull by the horns and open the Clubs' Union to all Guy's women.

Finally, Sir, I would point out that the nurses have ungrudgingly shared their swimming-bath with us in the past. *Dare Quam Accipere*!

Yours, etc.,

R. G. WATSON,

Norton, South Farnborough, Hants.

"George and Margaret"

ON Friday and Saturday, June 8th and 9th, Farnborough Hospital Dramatic Society presented a play, "George and Margaret," by Gerald Savory. Forewarned, as we were, by the difficulties accompanying this production, we were agreeably surprised by the excellent rendering of this play. After a rather slow and trepidous beginning, as usually accompanies an amateur production, the actors soon showed themselves in their true worth. Outstanding, from a generally high standard of acting, was Mr. John Crossley's performance as Malcolm, a "daddy" of extreme

charm. His wife, Alice, was admirably played at extremely short notice by Miss Eileen Shepherd, the producer. These two, with their fractious children, played by Miss Denise Sandford, Mr. David Oriel and Mr. Graham Blewett, satisfactorily portrayed the very typical and lovable family around which the rather thin plot revolved. Mr. Peter Carton-Kelly as Roger, the shy young musician, very ably played the love scene with Miss Denise Sandford, so often a stumbling-block, and gave us the happy ending so necessary for such a story. The servant problem was coped with by Miss Olive Heath and Miss Irene Rudd. One left in the hope of seeing this team in a play and setting more worthy of their capabilities.

J. L. H.; P. R. S.

Sector 10—House Officers

MAY 1ST TO JULY 31ST, 1945.

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S. Irvine, R. E. (B.2) Pentney, B. H. (B2) Trounce, D. Q.(B.2) May, P. R. A. Thomas, J. M.	Batty Shaw, A. Reinhold, J. D. L.	Thompson, R. C. W. (B.2) from Wildernesse.	Hilton, S. M. (B.2) to Preston Hall. Nicholson, D.P., to Farnborough.	
WILDERNESS.E Macrae-Gibson, N. K.	Woodside, R. M.		Thompson, R. C. W. (B.2) to Guy's.	
JOYCE GREEN. Lloyd, D. O.	Vidot, C. C.	Gibbs, A. E. (B.2) from Preston Hall.		Jones, E. C. C. Lillywhite, W. H. Merrick, H. P.
PRESTON HALL.		Hilton, S. M. (B.2) from Guy's. Evans, M. E. (B.2) from Farnborough.	Gibbs, A. E. (B.2) to Joyce Green.	
ORPINGTON. Williams, O. H. E. (B.2). Van Diggelen, H. (B.2). Wheatley, D. P.	Cashmore, A.A. Nicholson, N. G. (Student).			Keates, M. D. Wright, E. A.
FARNBOROUGH. Haas, G. J. (B.2) Brittain, R. G. L.		Nicholson, D. P. from Guy's.	Evans, M. E.(B.2) to PrestonHall	Brightwell, P.
PEMBURY. Macdonald, I. (B.2) Watford, N. C. T. Dixon, A. St. J. Murphy, E. G.	Wallace, J. D. (Student).			Dickie, A. B.
SOUTHERN. Ebsworth, J. S. (B.2). Leeson, P. C.	Bensted, J.P.M. Davies, D. Lewis, J. W. (Student).			Dodd, F. G. B. Godfrey, L. W. Lewis, H. J.
QUEEN MARY'S.	Rudman, D. J.			Johnson, W. C.
LEWISHAM.				Allen, R. A.
ST. ALFEGE'S	Walton, R. G.			

Sport

Cricket

GUY'S *v.* BROMLEY TOWN.

(*Played at H.O.P on May 26th.*)

Result: Won. Bromley Town, 87 Guy's, 97

Guy's again won the toss and put their opponents in on a sodden wicket. The fast bowlers opened the attack, but gained only moderate success. In time these were replaced by Graham and Webb, who found plenty of life in the pitch. Graham, bowling his slows to a distant and well-placed field, obtained considerable success, ending with the notable figures of six wickets for 36. Webb time and again beat the bat, only to beat the wicket

likewise. Despite excellent bowling he was credited with but one wicket for 23 in sixteen overs. The Bromley side never really got going against the attacking bowling and were dismissed for 87.

Guy's went in to bat after a shower. The wicket became more treacherous. Wicket after wicket fell; with seven down Guy's had scored 24. At this point Trist came in and batted confidently, hitting the bad ball hard. He was joined by the captain, Carton-Kelly, with the score at 52—still a critical position. At 63 Trist was run out having scored 32. The situation was again tense. Webb joined the captain and the score mounted. With only minutes to play and Guy's needing two runs to win Carton-Kelly hit a high difficult catch to cover. The catch was dropped and the match was won.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, D. J. Sheerboom, W. B. Webb, J. D. Williams, I. A. H. Munro, W. A. Evans, W. H. Garland, I. L. Busbridge, G. P. Billingham.

GUY'S *v.* OLD RUTLISHIANS.

(*Played at Merton Park on Sunday, May 27th.*)

Result: Won. Guy's, 106; Old Rutlishians, 62.

The toss won, Guy's went in to bat, but were soon in difficulties. With five wickets down only 22 runs had been scored. It was again left for the captain, Carton-Kelly, to restore the situation. This he did, scoring an enterprising 33, ably supported by Garland, who hit well for his 27. Guy's, at the close of the innings, had scored 106.

The Rutlishian side never looked dangerous. The bowling, skilfully handled by Carton-Kelly, proved too much for them. Carton-Kelly himself clean bowled three wickets and had a fourth caught by Evans. Evans's fielding was praiseworthy; three wickets fell to his catching. Webb shared the bowling honours with four for twenty-one. Carton-Kelly's analysis was four for 10.

The Old Rutlishians were dismissed with ten minutes to spare for 62 runs.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, D. J. Sheerboom, I. A. H. Munro, W.B. Webb, W. H. Garland, W. A. Evans, K. G. B. Pritchard, G. P. Billingham, J. B. Parsons.

GUY'S *v.* MIDDLESEX HOSPITAL.

(*Played at H.O.P., Saturday, June 2nd,* 1945.)

Result: Won. Scores: Guy's, 178; Middlesex Hospital, 58.

Guy's won the toss and batted. Runs came quickly and the hundred soon went up. The main run-getters were Garland (32) and Munro (21); Williams also contributed a useful 16. Wickets began to fall while the runs mounted. Carton-Kelly again distinguished himself with a characteristic 30. At the close of the innings Guy's had amassed 178 runs.

Middlesex never seemed to settle down to the bowling of Trist and Carton-Kelly, who took six of their wickets for 24 runs (Trist, three for 6; Carton-Kelly, three for 7). The remainder of the wickets fell for a further 34 runs, Graham taking three for 21. Guy's won the match comfortably by 120 runs.

Team.—L. D. Carton-Kelly, E. W. Graham, D. J. Sheerboom, A. E. Trist, W. B. Webb, J. D. Williams, W. A. Evans, W. H. Garland, K. G. B. Pritchard, I. A. H. Munro, G. P. Billingham.

GUY'S *v.* FINCHLEY C.C.

(*Played at Finchley on Sunday, June 3rd,* 1945.)

Result: Lost. Scores: Finchley C.C., 131 for five wickets; Guy's, 80.

Guy's chose to field and the home side treated their bowling with extreme reverence. In two hours only 90 runs were scored. A bright fifteen minutes, however, enabled Finchley to declare with 131 for five wickets. J. W. Levy, London Fire Force captain, scored a very sound 62. Carton-Kelly must be congratulated on the handling of his bowlers and also upon his own remarkably steady display—fifteen overs for only 31 runs. The Guy's fielding was of a high standard throughout Finchley's innings.

Guy's, going in to bat, went for the runs, but in the venture lost wickets. The only batsman to reach double figures, and, indeed, to show any ability to score fast and meanwhile retain their wickets were Williams (20) and Graham (25). The last five wickets fell for a handful of runs and Guy's were dismissed for 80.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, D. J. Sheerboom, G. Thompson, W. A. Evans, G. P. Billingham, I. L. Busbridge, K. G. B. Pritchard, J. D. Williams, H. M. C. O'Driscoll.

GUY'S *v.* ST. THOMAS' HOSPITAL.

(*Played at H.O.P., Saturday, June 9th,* 1945.)

Result: Won. Scores: St. Thomas' Hospital, 68; Guy's, 71 for four wickets.

St. Thomas' won the toss and decided to bat. They were, however, soon in trouble against the fast bowling of Trist and Carton-Kelly. They lost five wickets for 12 runs. The situation was momentarily improved, but they finally returned to the pavilion with 68 runs. Trist bowled extremely well, taking five wickets for 10.

Guy's passed the St. Thomas' total with four wickets down, Munro contributing 21, Garland 37 not out.

Team.—L. D. Carton-Kelly, E. W. Graham, W. B. Webb, I. A. H. Munro, J. D. Williams, W. H. Garland, A. E. Trist, R. G. L. Brittain, W. A. Evans, G. P. Billingham, M. J. L. Sykes.

The Boat Club

PUTNEY REGATTA, MAY 20TH.

It may be remembered that in the review of the Head of the River Race on March 24th, 1945, we said that with a little more training the VIII should do well in future races. Since then the crew has been going out twice a week, with the result that all expectations of improvement were amply realised in this second regatta of the season.

Thd VIII was entered for the Best Eights division, and was drawn to race against the Metropolitan Police and London Hospital in the first heat. Guy's had the middle station with the Police on their Surrey side and London on the Middesex. At the start from the "Crabtree" the main opposition came from the Police, who kept a short canvas behind Guy's for about the first thirty strokes; but after that the latter's lightness began to tell against the more stolid weight of the Police, who were gradually left behind. At Beverley Brook the VIII was leading the Police by a length, and London were about two lengths behind. These distances were increased by a couple of "10s," which were well backed up by the crew until the finish was reached with Guy's winning by about two lengths from the Police, and London a length behind the latter.

The crew then adjourned for a well-earned lunch and attempted sleep before meeting Gladstone R.C. and Putney Town in the finals at four o'clock.

This race was of much more serious stuff than the first, for Gladstone were second Head of the River in March, equal with Imperial College, who had just been beaten by Putney Town earlier in the day.

At the start of the mile course Guy's again had the middle station with Gladstone off the Surrey bank and Putney Town on the Middlesex side. The crew took the VIII away with a strong firm start, which resulted in a three-quarter length lead over Putney; but with Gladstone gradually overtaking Guy's. This was unfortunate, for the Surrey crew, instead of keeping to their station, edged over to the middle, knocked against bow's blade and eventually went across Guy's bow, leaving that crew to put up with their wash. By this time Guy's cox was forced to use his rudder to avoid hitting the Putney oars and, in taking this avoiding action, the boat was so slowed down, that Putney quickly regained their three-quarter length, and left Guy's about a length down. However, in spite of this setback the crew backed up stroke magnificently, and at Beverley Brook a well-timed "10" decreased the distance to three-quarter length, which the crew maintained until the finish. Gladstone ended two lengths in front of Guy's.

The VIII is to be congratulated on two very keen races.

The next two events of the season are the United Hospitals Regatta on June 23rd, and Henley Regatta on July 7th.

The Crew.—Bow, J. G. Brett; (2) C. C. Bull; (3) C. M. Williams; (4) J. Inskip; (5) A. F. Crick; (5) F. de Hamel; (7) T. H. S. Burns; stroke, R. T. Lowein (captain); cox, A. Shotts.

Hospital Information, etc.

Papers by Guy's Men

Alcock, Arnold. Sulphonamide-resistant-Penicillin sensitive. *Brit. Med. J.*, 1945, i, 735.

Allen, Clifford, and Broster, L. R. A further case of paranoid psychosis successfully treated by adrenalectomy. *Brit. Med. J.*, 1945, i, 696.

Atkins, H. J. B., and Holden, B. Treatment of battle casualties, second stage in two-stage operations. *Lancet*, 1945, i, 622.

Beach, W. V. Inguinal hernia, *Ibid.*, 499.

Bowen, W. H. Obstructive appendicitis. *Brit. J. Surg.* 1945, **32**, 468.

Bunyan, John. Surgical treatment of trench mouth. *Dental Gaz.*, 1945, **11**, 406.

Chapple, H. Prolapse of the rectum in women. *Ibid.*, 661.

Gillespie, R. D. War neuroses after psychological trauma. *Brit. Med. J.*, 1945, i, 653.

MacIntosh, R. R. Experiments in artificial respiration and in asphyxia. *Proc. Roy. Soc. Med.*, 1945, **38**, 306.

Mutch, N., and Rewell, R. E. Penicillin by inhalation. *Lancet*, 1945, i, 651.

Nelson-Jones, A., and Another. Tracheotomy in bulbar poliomyelitis. *Lancet*, 1945, i, 561.

Pilbeam, J. F. Orthodontic teaching in post-war years. *Dental Rec.*, 1945, **65**, 101.

Rushton, M. A., and Walker, F. A. The uses of the screw-pin in Maxillo-facial cases. *Brit. Dent. J.*, 1945, **78**, 289.

Symonds, C. P. Prognosis in closed head injuries. *Brit. Med. Bull.*, 1945, **3**, 14.

Thompson, R. H. S., and Others. Treatment of post-arsphenamine jaundice with sulphur-containing amino-acids. *Quart. J. Med.*, 1945, **38**, 35.

Walker, F. A. A screw-pin for use in connection with mandibular fractures and grafts. *Brit. Dent. J.*, 1945, **78**, 266.

Eason, Sir Herbert. Presidential Address at the opening of the 164th session of the General Medical Council. *Med. Pr.*, 1945, **213**, 366.

The Services

AWARDS.

M.C.

Captain C. H. Watts, R.A.M.C., in recognition of gallant and distinguished services in N.-W. Europe.

Capt. E. H. Williams, R.A.M.C., in recognition of gallant and distinguished services in Burma.

T.D.

Captain G. A. Lawson-Brown, A.D. Corps, has been awarded the Efficiency Decoration of the Territorial Army.

Mentioned in Dispatches.

Brig. (Acting) R. H. Lucas, C.B.E., M.C.
Major (Temp.) D. A. G. Brown, R.A.M.C.
Major (Temp.) E. E. Evans, R.A.M.C.

M.B.E.

Miss Florence Victoria Wittrick, Acting Matron, Guy's Hospital, London, S.E.1.

CASUALTY.

Sqdr.-Ldr. J. N. Williams, R.A.F.V.R., died of injuries.

Change of Address

R. R. Burn, Captain, R.A.M.C., 53 Field Regt., R.A., C.M.F.

J. W. A. Crabtree (15736), Captain, I.M.S., c/o Grindlay & Co., Bombay.

Miss C. H. Little, P/257410 Q.A.I.M.N.S.R., 66th (Br.) General Hospital, C.M.F.

Joyce C. Widlake, S.R.N., The West End Hospital Unit, Princess Louise Hospital, Pangbourne Avenue, W.10.

Appointments

Major-General W. H. Ogilvie has been appointed Senior Surgeon to the Royal Buckinghamshire Hospital, Aylesbury.

Miss B. Lydon, of Princess Beatrice Hospital, Earl's Court, appointed Matron of Ancoats Hospital, Manchester.

Miss M. Foster Smith, of Albert Dock Hospital, appointed Matron of Seamen's Hospital, Greenwich, S.E.10.

Mr. T. B. Layton has been recalled as a district medical officer in Italy to take over a more senior post in Austria.

Births

BEHRMAN.—On April 23rd, 1945, at 27, Welbeck Street, W.1, to Doris (née Engelbert), wife of Dr. Simon Behrman, 33, Harley Street, W.1—a son.

CARPENTER.—On May 20th, 1945, to Mary (*née Griffin*), wife of Eric Brodie Carpenter, L.D.S.—a daughter.

BORGHYS.—On May 24th, 1945, at the Kenwood Nursing Home, London, N.10, to Cynthia (née Slater), wife of Paul Borghys, Captain, Army Dental Corps—a sister for Diana (Helen).

JONES.—On June 6th, 1945, at Gerwyn Hall Maternity Home, Wrexham, to Olive (née Thomas), wife of Howell P. Jones, Lieut., R.A.M.C., of Port Helen, Rhewl, Ruthin—a daughter.

Deaths

LOUD.—On June 9th, 1945, at Amberley, Burgess Hill, Frank Loud, M.R.C.S., late of Lewes and Hove.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1486 *7th July, 1945* *Ninepence*

PASSIM

THE uneventful character of the summer holiday months of July and August have, in the past, frequently compelled the writers of this page to give full rein to their imaginations. This summer, too, we lie in the doldrums between activity past and activity future and the quietude of summer is upon us. In the outside world, to be sure, there is strife enough; "the health of the people" has probably never before been so prominently blazoned as a crucial election issue; nor has such widespread interest been raised in affairs of national health since 1912. This puts the medical man and woman in a better position than any to estimate the values of the proclaimed policies or, more important, of the true intentions of the various parties.

Meanwhile, in the Hospital, and under the superficial strata of uneventfulness that we have mentioned, the planning of peace-time enterprises and the winding-up of war-time activities go forward. As regards the first, a sub-committee of the Clubs' Union has recently been set up to discuss the future organisation and structure of the Union. Concerning the second, the Hospital fireguard rota is being disbanded. This organisation started, at the outbreak of war and when no one knew quite what to expect of Germany's Luftwaffe, as a body of forty or fifty students residing in the College. After a few months of the "phoney war" the number of enrolled members was reduced, only to be increased again when the "blitz" started. In 1941, after the destruction of the College, the members of the rota moved abode, first, to Dorcas Ward and, finally, to the Hostel, thus adding yet another chapter to the history of that building's chequered career. Throughout the major "blitz" of 1940–41 and the minor one of 1944 the rota's job was still chiefly one of fire-watching, but with the advent of flying-bomb and rocket, emphasis shifted to reception and treatment of casualties.

ON Wednesday, June 27th, 1945, the social life of the Hospital was enlivened by a Reunion and Victory Ball, given by the Matron, Governors and members of the Staff in the Vintner's Hall, which was kindly lent for the occasion by the Worshipful Company. A R.A.F. band provided the music and, if one can judge by the enjoyment that was obtained, the affair was a great success.

WE welcome Professor T. B. Johnston, who, as Superintendent, has returned to Guy's. Dr. Bishop, the acting Superintendent during the war, returns to the Warden's house.

READERS will want to join us in congratulating Air-Vice-Marshal Conybeare on his recent promotion. At the same time we learn that Mr. Layton is to be appointed to Belsen hospital camp, and not, as was stated in "Hospital Information" last week, to a post in Austria.

AFTER thirty years of service with the Hospital, Miss Ryan, Chief Clerk in the Dental Conservation Room, is leaving her post to go into what we hope will be a long and happy retirement.

MINDFUL of the neighbourly interest and generosity with which St. Mary's Hospital greeted our Rugger Centenary last year, we should like to reciprocate their compliments for their Hospital centenary this month.

Diseases of the Herd

A Clinical Lecture by T. B. LAYTON, D.S.O., M.S.

I WANT to talk to you to-day about herd disease, for I think you must recognise such things in the pathology of the future. But, first, I want to speak to you about the influence of the human mind upon the body, for it is not sufficiently appreciated in our western world. I believe that the mind of man may so profoundly influence the processes of the body that no investigation done on any animal can be interpreted as exactly applicable to him, not even when the experimental animal is our first cousin the chimpanzee. Such views as this are anathema to-day in our medical world. When I enunciated them at an otological meeting some years ago the distinguished professor, who had left for a while his glass tubes and the quiet of his laboratory to enter into the turbulence of a clinical meeting, jeered at them in his reply to the discussion that had arisen out of the lecture he had given us.

The East knows much more about these things than do we in the West; but it seems to know them with the subconscious mind from which they have not as yet been brought up to the level where they can be taught to those who believe in them or expounded to those who do not. During the active period of my professional life, however, our conceptions of the nervous system and of the mind have so changed that it is almost impossible to think what, at the beginning of the century, was thought about the way in which man thinks. It is forty years last month since I became a full surgeon's dresser, from which, I think, we can date the student becoming a clinician. During these years five new conceptions concerning the nervous system, each revolutionary in itself, have come into neing. The first of these was Sherrington's integrative action of the nervous system; the second was Freud's emphasis on the subconscious; the third was Wilfred Trotter's description of the instinct of the herd in peace and war. The fourth was Pawlov's conditioned reflex. The last I cannot date, because I cannot find anything in the writings of Elliott Smith in which he enunciated it. But teach it he did. It was that man has reached his position in the animal world that he now holds because in the evolution of his central nervous system he never specialised.

In what I am going to say please accept that man's social evolution is the interpretation of the continuation of the evolution of his mind. We may hope that what Elliott Smith taught was the cause of man's guidance in the past may continue to act in the future, and so, when I speak to you of the herd, remember that we are not all herd. The solitary animal comes into the mental make-up of all of us; and it may be that the varying degrees in which the solitary and herd animals are mingled in each of us may determine, in some degree, the differences in our character. There may even be a third factor such as the family animal, unless the family represents the compromise between the limit of sociability of the solitary animal and the minimal of the herd. If so, this may be adduced as evidence that the family is the physiological basis of our social life.

I want then to take you a little further in this question of the herd, and to ask you to consider whether there may be herd diseases. As clinicians we deal with individual cases which may be sporadic or may be one of many recurring all at once and, if there be a micro-organism associated with these, we call them epidemic. For many years we have spoken of these micro-organisms as causative; but, if we can be certain in a world of doubt, it is that the organism is not "the cause" of infective disease. Such a disease is, rather, the disturbance of a true symbiosis, or the incidence of a false one between host and parasite. Sometimes, however, epidemic diseases change and assume a new character that cannot be explained by the accepted rules of epidemiology. Take the story of plague. It is probable that Hippocrates "was familiar with this in its sporadic, but probably not in its epidemic form,"[1] and medical officers have during this war been getting experience of such cases; but usually plague comes to our notice as an epidemic, of which the one that you know best is the plague of London, for even if you have not read Defoe's history you have probably read Harrison Ainsworth's story of "Old St. Paul's." This was a local epidemic and did not spread much beyond London. At least once, however, plague has assumed a character as different from such epidemics as these are from sporadic cases.

You have all heard of the Black Death; but I wonder if you realise the extent of its ravages or its influence on the life of the day. It occurred in the middle of the

fourteenth century, starting in England in August, 1348, and began to abate in the autumn of 1349. One-third to one-half of the population died and "no one disputes the marked influence of the pestilence in rural society."[2] The loss of grown men obliged the lords to look out for fresh tenants, the shortage of labour produced a marked rise in wages, it loosened the bonds of law, it contributed to the decay of the demesne, and it led to the peasants revolt of 1381; while it was one of the reasons why William of Wykeham founded his college because of the reduction in the number of the clergy by it.[3] It involved Ireland,[4] in the winter of 1348–49, and resulted in a scarcity of labour, a decay of learning, and a relaxation of the bonds of society. We read[5] of it in Florence and in Catalonia; but the part of Europe where its ravages were most devastating seems to have been the Scandinavian countries, all of which were involved. It depopulated them almost completely, and in Norway it denationalised the church and the nobility. Amongst other things it stimulated the literature of astrological medicine and, by the shock it gave to society, it fostered the growth of vulgar witchcraft.[6] Our ordinary hypotheses of epidemiology cannot explain all this. The rat could not have run all the way from Florence to Trondjem in the time, nor the flea have hopped it. The man and the bacillus must, it would seem, to have been in contact for some time and then something to have happened which resulted in the Black Death. I suggest to you that there was something in the mind of man analogous to that "exquisite sensitiveness of the herd" of which Wilfred Trotter[7] speaks.

Do not think such things only happened in the Middle Ages. Men of my age have been through a similar experience. My grandfather saw epidemic influenza in 1847; my uncle in 1889. From then on it remained sporadic, occurring almost entirely as a disease of the well-to-do. And then, in a few months, more died in India alone than were killed in all the armies of both sides in five years of war. This also was an infectious disease, this one from droplet infection, but from the rate at which it spread the human race could not have spat around the world in time. It was called a "pandemic," but you do not explain an unknown pathology by giving it a new name that suggests a resemblance to something partly known.

Let us pass on to other infective diseases which are not epidemic. Tuberculosis would seem to me to be a disease of the herd of that type. It is beginning to be classed as epidemic; but that is but to confuse the two words "epidemic" and "infective." It is a sporadic infective disease very common in man. We think over here that it is associated with want of ventilation, and grey weather with its absence of sun; and then you go to Sicily, where the population lives in the street and there is an excess of sun, and there you find that tuberculosis forms a problem as great as it does with us. Isolation of contacts may be a necessary administrative measure to protect members of the family; it will do nothing to eliminate the disease from the herd. And though I do not want to suggest that the influence of the mind upon the body is the only factor in herd disease, remember that the most important factor in the recovery of the tuberculous patient is his mental condition.

But tuberculosis is not the world's greatest scourge. To malaria must be given that pride of place, and I long wondered whether I could include it among my category of suggested diseases of the herd. I cannot do so. I have long known it as the most entrancing of all diseases clinically owing to its protæan manifestations; but a few months ago I realised it to be the same from the preventive aspect on coming across one of the most exciting books[8] I have ever read. The disease is infective and, as in plague, access comes from the bite of an insect, but the infective organism is far removed biologically from the bacteria. It is not epidemic, but differs from tubercle in this negativity, being definitely dependent upon sesonal conditions. It is easy to think that with the discovery of the parasite and of the role of the mosquito the malaria problem is solved; but on going into it you find that these have but increased the difficulty of the question, and the titles of the chapters in Dr. Hackett's book merely tend to illustrate this. They deal with: A House "Divided." The Malaria "Puzzle," Anophelism "without" Malaria, "The Complexity" of the Parasite, The "Peculiarities "of Temperate Climate Malaria. All are doubts, and if we cannot bring these into the conception of man as a herd they only serve to show that there is some *quartum quid* of which we are as ignorant as were our forebears of bacteriology before the time of Pasteur and of Lister.

And now to turn from infective disease to other conditions. The world is very sick and we are sick with it. Are we not all in different degrees suffering from "herd shock"? I will not attempt to detail symptoms in the herd to correspond with those of this condition in the individual, nor am I going to try to contrast a debated

pathology; but I am going to suggest that the treatment of the two must be on similar lines. In a case of profound shock your treatment is to resuscitate; unless you can do this you will lose the patient; and so, I believe, it is with the most advanced forms of herd shock of which I have as yet had no experience, but I believe that if you cannot resuscitate the group it will die as a necessity. Once you are past that the patient still needs help; but an effort on his own part must be made if the nourishment or other assistance given him is to do any good. Then comes the time when the effort on the part of the patient is the essential treatment, though help may still be needed. But in both these cases the help must be given with kindly encouragement and in a friendly manner. Any suggestion of an opposite approach but throws the patient back. Finally there is the stage in which his recovery is in the patient's own hands with the possible addition of a good talking to from doctor or nurse, again kindly though firm. In all these stages, except the first, the mental treatment is of far more importance than the physical. Beyond the necessities of life it is the essential. When this classification is transferred from the individual to the herd, the people of Sicily, for whom I have been working, came somewhere midway. They are not starving; they are short of food just as we are; bread is rationed and there is also less to be had than what we eat. In spite of this rationing distribution is more inequitable than it is with us, prices are high and I suspect still mounting; there are therefore cases of undernourishment, but I only saw one child in hospital in whom I could put my thumb and middle finger around the thigh. They have had a bad time just as we have, but with fighting in their own towns and across their country as we have not. But they have had two other things that we have not had. They have been ruled by foreign conquering armies for a space of two years, and they have been cut off from the outside world for five years, or, rather, for ten, for it dates from the time when we imposed sanctions. The former makes it difficult for them to start again. The latter is particularly important to a small area. We at least have had thought coming in from the United States and from Russia; they from nowhere, not even from Northern Italy for the last two years. We have had some goods come in from the rest of the world. They have had none. The things they most need—linen, thread, blankets, surgical instruments, paint and glass, catgut and gloves—are all things of which we are in short supply; but they have had none for all these years. It was said to me before I went that what I should do would depend on what I had in my pocket. That is quite true; but it is remarkable what one could do by one's mere presence before any medical supplies were brought into the country. To those that were down your mere presence gave a spur; to those that were up an encouragement. But I think that the essence of the thing is to do it by kindness. If they think you have given them a promise it is not the way to tell them they are "God-darn liars" if you have not. You have to explain to them that supplies are limited and have to be spread over many peoples. Then they will understand and go on doing their best with what they have until the lesser amount arrives. And so, when dealing with excessive demands. It is not the way to say say, "Of course, all that is no good" and set them down to make out new lists. You want to reason with them, even to joke with them, as when I asked the mother superior why she asked for five hundred sheets; and she replied it would be a nice number to have. When I pointed out that there were only fifty beds in the hospital, she took it in quite good part and we settled down to what was really needed. Then I think you do not want too rigorously to stick to the bounds of your job. Recovery of herd shock is going to come from what each individual does on his own outside and beyond the strict limits of his task. There is something that everyone can do from time to time over and above his exact duty. I would then again refer you to Trotter's "exquisite sensitiveness of the herd" and ask you to believe that what you do for one you will do for the many. That by helping the one you have have an effect upon the many. That by helping the few you may have an effect upon the whole community even if you do not seem to have done anything positive at all.

And with these remarks I will leave you to think for yourselves whether there are such things, physical or mental, as diseases of the herd.

REFERENCES.

(1) Raymond Crawfurd. "Plague and Pestilence in Literature and Art, 1914, page 77.
(2) "Cambridge Economic History," Vol. I, pages 512–515.
(3) "Cambridge Mediæval History," Vol. VIII, page 693.
(4) *Ibid.*, pages, 456, 539.
(5) "Cambridge Economic History," Vol. I, pages 341, 350.
(6) "Cambridge Mediæval History," Vo. VIII, pages 540, 680.
(7) "Instincts of the Herd," 1915, page 110.
(8) "Malaria in Europe an Ecological Study," by L. W. Hackett. London: Humphrey Milford, 1937.

In Memoriam

R. G. GAYER ANDERSON.

ON June 16th, 1945, there died at Lavenham, in Suffolk, a Guy's man who will be remembered with affection by his contemporaries round about the turn of the century.

"John" Anderson was a personality throughout his student years. Gay and witty and never unkind; he was a great sportsman, and a prominent forward in some of the best rugger teams we ever put into the field.

He aspired to no academic distinction, but was as sound a man as ever qualified, and that in 1903, a vintage year which included Arthur Hurst and Arthur Brailey. He joined the R.A.M.C. and was one of "Willie" Lane's first house-surgeons when he had attained full surgeon's status on the staff.

Anderson became an excellent surgeon and carried Lane's bone-plating technique to the Cambridge Hospital at Aldershot, where he immediately attracted attention and might have gone the whole distance. But he was an antiquary at heart; in his student days he was always on the look-out for old books, pictures and trinkets in the back streets of the Borough, and was already regarded by us as something of an expert.

Quite early in his service he went abroad and found himself in the Sudan, where he was quickly attracted to anthropology, and one soon read interesting papers from his pen in the archives of the Wellcome Research Institute in Khartoum. His attachment to the Egyptian Army led naturally to a keen interest in Egyptology, and thereafter he was drawn more and more away from professional work and, in the end, achieved a world-wide reputation as an authority on Egypt, past and present.

During World War No. 1 his services were mainly employed in secret diplomatic work, and he had many exciting experiences and dangerous assignments.

His last official appointment was as Oriental secretary to Lord Allenby, when he was High Commissioner in Egypt. Thereafter he retired with no higher rank than Major in the R.A.M.C., but a considerably higher status in the Egyptian service; in fact, as a General (Lewa). By this time he had made a very valuable private collection of Egyptian treasures, and was already closely associated with all the best-known Egyptologists of the day in Europe and America. Diphtheria, during the 1914–18 War, undermined his constitution, and he never fully regained his previous robust health. For the last twenty years he divided his time between Cairo and the ancient wool-town of Lavenham; it is characteristic of him that he should make his English home in this haven of the National Trust.

A few years ago he presented his private collection to the Egyptian Government; it was housed by them in a suitable building in Cairo, and he was installed as curator during his life-time; this became the Mecca of informed tourists and many famous names are inscribed in the visitors' book. He was created a Pasha in 1941.

"John" Anderson was one of my closest friends in student days, and we met as often as possible in after years, both at home and abroad, but always kept in touch by correspondence, his last letter being as recent as March of this year when his health was failing, but he was unafraid of "the little time one may have left here below."

Now he has gone, but his memory remains in the hearts of his friends. C.H.R.

Leave in Rome

By C. W. MARSHALL.

FOR some time now the leave roster to Rome had been open and, as each party returned full of the wonders of the Eternal City, it was with very pleasurable anticipation that your correspondent received notice of his turn and, collecting various guide-books, set to to prime himself with local information. It turned out to be quite a Guy's dinner in the mess when one sat down with Gover, Farris, Fowler, Hammond and Stephens to discuss this expedition. It will be appreciated that local leave does not crop up very often, but, when it does, one appreciates all the more that life has its compensations, and sets out to enjoy them to the full.

The leave truck bowled along through countryside, full of interest, which was looking its best in the spring sunshine, and in due course Rome came in sight, the dome of St. Peter's towering above all other landmarks; formalities were soon completed and the leave hotel reached. This turned out to be a first-class one with every creature comfort. How pleasant to meet a proper bathroom again after the baths of lead or of marble which had succeeded the original canvas ones, and to have plenty of water,

f. and c. (one soon remembers that the " c " is for " *calda*," not for " cold.") A pleasant feature of a leave hotel in such a centre as Rome (shared, I am told by more travelled people, with Shepheard's in Cairo) is the number of old friends one runs into. This trip was no exception, but my only Guy's contemporary who showed up was Sheldrake; calculation of the last meeting time was hastily abandoned for reminiscing. The local edition of the *Union Jack* carried a column of details of the various clubs, theatres, cinemas and amenities, and the Education Officer had arranged for guides and had prepared some excellent literature on the more important things to be seen, which made it very easy to draw up one's plan of campaign. However, many have written on the subject of Rome, and it is not proposed to try and compete here with the guide-books; it will suffice to comment that photographs and the written word had not left that impression of the full magnificence that must have belonged to Imperial Rome which is given by an actual visit.

The Romans appear well turned out, and it was a pleasure to see well-dressed civilians after the more shabby regions in which one had been working. It was intriguing to notice that the famous Roman nose is no figment of the imagination. Shop windows appeared well stocked, but prices of clothes in particular were startlingly high. Some of the more unique pieces of statuary had not yet emerged from where they had been taken for safe keeping, and others, too big for removal, such as Trajan's column, had been expertly bricked in or sandbagged, but in general such precautions were not conspicuous. It was gratifying to see that the only evidence of bomb damage was that of a highly successful precision attack on the main railway station. One learnt that the Nazis had not been great sightseers, and that during their occupation most of the show places had been kept closed. As befits a Guy's man early visit was made to the grave of John Keats; this, in spite of the dropping of German bombs close by, is quite undamaged, and is a most peaceful spot among the cypresses under the city wall. The famous inscription, " Here lies one whose name was writ in water " still stands; in fact, his name appears nowhere on the actual stone, though it is recorded nearby and that of his friend Joseph Severn, buried at his side.

Here one sees the other side to the English slogan " No popery." The Protestants had originally to be buried " *extra muros*," and it was only by an " exceptional concession " about the year 1738 that this cemetery just inside the walls was permitted. This concession is attributed to the influence of the " Old Pretender," then resident in Rome. Later on, in St. Peter's, where the dimensions of the principal churches of the world are marked on the floor of the nave, one noted that St. Paul's Cathedral is described as " S. Paol. Londininiense Fanum." Incidentally, it appears that St. Paul's only covers just more than half the floor space of St. Peter's.

In due course the Forum region was explored with a guide who was armed with pictorial reconstructions of the ruins, drawn on the lines indicated by contemporary descriptions, and the imagination was soon stimulated to recreate the scene. What ghosts of one's schooldays arose as one trod the Capitol Hill, the Tarpeian Rock and the Via Sacra, route of all the " triumphs."

Turning to relics of early Christianity, it had not been appreciated that St. Peter's is built over the tomb of the Apostle and adjoining the site of the Circus where he was martyred; also are preserved the prison cells (and what a very gloomy dungeon) to which tradition assigns the incarceration of St. Peter and St. Paul, and a great focal point for pilgrims, the contemporary marble staircase from Pontius Pilate's palace at Jerusalem.

The Catacombs, of whose many miles one inspects a typical section, are full of interest, consisting as they do of long underground galleries, with niches (including small ones for children) cut in the walls for the bodies, the niche then being closed with a stone or marble slab. One had thought of them as refuges from persecution, but it appears that they were lawful Christian burial places under the pagan Emperors, and that refuge and clandestine worship were a secondary use. Rock burial was apparently a Jewish mode of disposal which was maintained by the Christians.

Impressions left of St. Peter's are of its imposing dimensions and the dizzy height of its dome, and of magnificent sculptures and mosaics with which every portion of its interior is decorated. The Sixtine Chapel and the famous frescoes leave one astounded at the genius and industry of Michel Angelo. Outstanding in the museums of the Vatican are examples of sculpture and mosaic work from Hadrian's Villa at Tivoli. These, together with memories of well-preserved villas at Pompei and Herculaneum, all assisted in giving a perception of the luxurious standards of living maintained by the Emperors.

Ultimately one left very much refreshed and encouraged by the sight of such a storehouse of treasures still very much alive after more than two thousand turbulent years.

Changing Clinical Horizons

By "UNCLE HARRY."

IT is reasonable to say that the clinical horizon of a country is determined by the diseases which commonly occur therein. Also, that the position which these diseases occupy in relation to the observer and that horizon is never static, but subject to continual change. From time to time a disease may become so prevalent that it assumes epidemic proportions and occupies the centre of the observer's field of vision, and there are other diseases which have been virtually eradicated and may be regarded as having receded beyond our clinical horizon and to have become extinct—as far as this country is concerned.

Galen used the word "plague" to describe any epidemic which caused great mortality rather than in the specific sense as indicating an infection with B. pestis, and it is probable that it was used in much the same sense by other early writers. What, for example, was the precise nature of the "Black Death" which swept, not only this country, but many other parts of the world about the year 1348 (?). We do not know. It may have been bubonic plague, but may well have included cholera and smallpox. Bede recorded an epidemic in 664 A.D. which was probably plague, and there was another in Rome in 690 A.D. which was certainly plague, for it was called "pestis inguinare."

In the fourth chapter of the first book of Samuel it is related how the Philistines smote the children of Israel and captured the Ark of the Covenant. In the following chapter it is recorded that the inhabitants of the city of Ashdod, to which the Ark was taken, were "smitten with emerods." The Ark was therefore moved to Gath, where "the men of the city, both small and great, were smitten with emerods in their secret parts." This caused the priests of the Philistines to advise them to return the Ark to the children of Israel, and to put inside it five golden emerods and five golden mice: "Ye shall make images of your emerods and of your mice that mar the land"—as a trespass offering. If you look in the dictionary you will see that "emerod" is said to mean "hæmorrhoid," and the two words are certainly similar in sound. But "emerod" is also defined as "a breaking-down blain or boil, a sore." I do not think there can be much doubt that the emerods mentioned in the Bible were buboes—for, after all, hæmorrhoids do not occur in epidemics. But the most remarkable thing is that the Philistines evidently recognised the part played by "mice" (which could just as well have been translated as "rats") in the spread of the disease; for the part played by the rat and by *Xenopsilla cheopis* was only determined by the Indian Royal Commission on Plague in 1902–4, although B. pestis had been discovered by Yerbin and Kitasato in 1894.

The Great Plague of London in 1664–6 was unquestionably plague in its highly virulent and infectious pneumonic form, which would account for the direct infection from person to person without the intervention of the rat and the rat-flea, although doubtless these also took a small part in the process.

"Ague," as malaria was always called in this country, was rife in the Middle Ages in England. It is often mentioned by Shakespeare, who made Sir John Falstaff "die of an ague." Even in living memory it was common in the Fen district, in Romney Marsh and in the low-lying area around the mouth of the Thames. Only a week ago I was told by a recent resident that it still occurs in the Lincolnshire Fens. I remember doing my first locum in the Romney Marsh district and seeing cases among the residents, who made a habit of keeping quinine in the house.

The remarkable thing about malaria in this country is that neither when it was at its worst nor since have any specific measures been taken to eradicate it. Its gradual disappearance has been due to the general improvement in sanitation and conservancy throughout the country. Anopheline mosquitoes are widely distributed all over this country, but, fortunately, not infected. Yet whenever British troops have been engaged in wars in malarious countries, their return home has usually been followed by local outbreaks among the civil population in the neighbourhood of garrison towns; hence the importance of rendering sufferers parasite-free. Soon after the last war I

was in a camp where three or four thousand boys, enlisted for " boys' service " in the peace-time forces, were in training. Cases of malaria began to occur in these boys who had never been out of the country. Once you have seen it, it is quite easy to make a clinical diagnosis and confirm it by a blood examination. But a doctor in this country, confronted by a case of malaria in a person who has never been out of the country, is apt to be puzzled, especially if he has never seen the disease. There was a derelict canal running through the camp which, when dipped, showed anopheline larvæ in myriads. Adult mosquitoes had been infected from demobilised men in the civil population. The dissection and recognition of an infected mosquito is quite easy and very useful.

The story of dysentery in this country is interesting and, in some respects, resembles malaria, in that no special effort has been made to eradicate it. At one time, under the name of " the Bloody Flux " bacillary dysentery was a scourge, not only to the inhabitants, but also to armies in the field. With the growth of towns, the provision of safe water supplies had to follow as a matter of course, and then the introduction of water-borne drainage. This removed two of the most potent factors in the spread of the disease—*i.e.*, unsafe domestic wells and the insanitary privies which usually contaminated them. In rural areas, however, matters were very different and the faulty privy and unsafe well continue. Hence it is that to this day, bacillary dysentery is endemic as a residual infection from the bad old days in practically every rural area which does not possess a main water supply and an effective drainage system. There are always enough undetected carriers to ensure that the disease is carried over from one season to another and the disease will continue until the defective privy and the unsafe well are abolished.

There was a time when the only kind of dysentery believed to exist in this country was the so-called " asylum dysentery." It is interesting to refer to the fourteenth edition of " Taylor's Medicine," published in 1911—only three years before the last war. This is what it says :—

> " Dysentery is especially a disease of the tropics, where it is endemic in certain regions. It is within the limits of 35° or 40° north and south of the Equator that it is especially frequent. It is not climate alone however that determines its occurrence, but rather terrestrial conditions, since many places are exempt from it, and those that are favourable to it are often also the homes of severer forms of intermittent and remittent fevers. In temperate climates epidemic dysentery results from overcrowding and insanitary conditions and occurs in military camps. . . . It has broken out in prisons under conditions probably dependant on impure supply of water or air. It is even now not uncommon in asylums for the insane where hygienic conditions may not be good, and its invasion is thought by some to be due to the lowered nervous force of the sufferers and by others to unfavourable local conditions such as habitual constipation. Sporadic cases of dysentery arise from unsuitable food, bad meat, or unripe fruit or from drinking water impregnated with organic matter."

So much for Taylor in 1911. The cause of all bacillary dysentery is infection with the causative organisms ; nothing more and nothing less.

If you have watched the Registrar-General's returns for the past few years you will have noticed that the figures have risen from fifty to seventy per week to upwards of five hundred. To a great extent this may be due to better recognition of the real nature of the diarrhœas which are common in rural areas ; but I am convinced from my personal experience that there are still hundreds, if not thousands, of unrecognised cases.

The extract from " Taylor," quoted above gives a food idea of the conception of dysentery in 1911. Small wonder that during the last war expert pathologists often failed to recognise the Entamœba histolytica, for which they frequently mistook the macrophages of bacillary dysentery. As a result many cases of bacillary dysentery were treated with emetin.

Here, then, are two major diseases which have moved towards and almost beyond the horizon, as a fortuitous result of the general improvement in the sanitation and conservancy of the country ; and they are still moving.

When I was a boy it was almost impossible to walk down the streets of any large town without meeting one or more people whose faces were disfigured by smallpox. I remember an epidemic near my home and the cold fear which took possession of the people—a people who knew only too well the danger of the disease and had so many living examples among them of its ravages. A large house in an isolated position had been converted into a temporary hospital. People used to go out and gaze at it from what they thought to be a safe distance, about a mile away, So great was their fear that nothing would have tempted them to go any nearer. Each day we used to hear of the deaths of people who were well known in the community and there seemed to be a sort of fascination about the place to which the victims were taken. I well remember our nurse taking me to look at it and warning me on no account to tell my mother that she had done so.

Does smallpox strike any terror into the people to-day ? Scarcely at all, because the possibilities of the disease are quite outside their knowledge and personal experience. So many people have been protected by vaccination and it is so long since it occurred in widespread epidemic form that its ravages have been forgotten ; and the voice of the anti-vaccinator is heard in the land.

There have been several epidemics of cholera in this country and tombstones can be seen in churchyards of London, of people who are said to have " died during the Great Cholera Epidemic." Since 1830, when it first visited Europe, there have been at least five European epidemics—1845–51, 1851–55, 1865–74, 1884–86 and 1892–95. In the Balkan war of 1913 and during the Great War of 1914–18, especially in the Balkans and Iraq, there were many outbreaks, but the disease did not spread as an epidemic beyond the seat of war. Cholera has been epidemic in Lower Bengal from the remotest times, and it is usually from there that epidemics have originated. The disease reaches Europe by three distinct routes, *i.e.*,—

1. *Via* Afghanistan, Persia, the Caspian Sea and the Volga valley.
2. *Via* the Persian Gulf, Syria, Asia Minor, Turkey-in-Europe and the Mediterranean.
3. *Via* the Red Sea, Egypt and the Mediterranean.

It follows the great routes of human travel and is spread chiefly by man. *It never travels faster than man can travel.* During the great religious pilgrimages hundreds of thousands of devotees are herded together under unbelievably insanitary conditions. Cholera breaks out among them and when they separate they carry the disease along with them as they disperse to their homes. At first its rate of travel did not exceed that of the caravan ; but with increased speed of communication and movement of peoples its rate of spread increased to that of the steamship and the railway. With the increased facilities for air-travel, the possibility of its more rapid spread must be envisaged. Unfortunately the limitations of space prevent me from giving personal experiences in this connection. In one case we did a blood agglutination and two stool-cultures from each of five hundred men and found that one was a carrier. About the same time we held up a plane which was only two days out of an endemic area—the quarantine period being five days—and arranged for its passengers to proceed under the system of sanitary surveillance as laid down by the Paris Convention, on their way to the United Kingdom.

The object of this short paper is to point out how certain diseases may advance and recede within the clinical horizon of this country and the great need for vigilance in the near future. Air travel has developed enormously during this recent war and civil air-lines both here and in the U.S.A. are making great preparations to deal with the great volume of air traffic which is confidently expected and will certainly occur. Speed of air travel will be greatly accelerated and it will be possible to travel from places as distant as West Africa and India within three days. It will thus be possible to become infected with a disease within such a radius and to land in the United Kingdom well within the period of incubation of smallpox, cholera, plague, typhus and various other diseases which are present may be outside our clinical horizon, but which we must be prepared to recognise without delay. The so-called " tropical diseases " must not be given scant attention " because we never get them here." They are important " pieces " which go to make up the giant jig-saw puzzle which we call Medicine. The picture cannot be completed without them.

Correspondence

TRAINING OF NURSES.

To the Editor of the GAZETTE.

SIR,—I would like to express appreciation of the letter from "Perseus" in your last issue. The training of nurses under the present system, however, is fraught with difficulties, not always understood by people outside the nursing profession. Lectures and classes have to be given at times when both day and night nurses can attend. Nurses' mealtimes and ward routine have also to be considered. It is particularly difficult to consider the wards, for at no time in the day is it easy to spare approximately one-quarter of the staff for one hour. The "block" system of training is the solution to the problem whereby the nurses have their lectures during periods when they are not working in the wards. We hope the Governors of Guy's will be able to introduce this system in the very near future.

I would like to add that tea is always available to night nurses before attending a lecture, and that it is exceptional to have more than one during a week. During all the busy war years at Guy's, on three occasions only has the lecture been cancelled "fifteen minutes after it was due to commence"; twice owing to a large intake of air-raid casualties, and once owing to a telephone message that had miscarried.

Yours, etc.,

FLORENCE TAYLOR (Sister-Tutor).

LAWN TENNIS CLUB.

To the Editor of the GAZETTE.

SIR,—I am sending herewith a letter from the Lawn Tennis Club. Members will be pleased to know that four grass courts have been, with much difficulty, prepared for their use at Honor Oak Park. Although it is now well into summer, the unhappy weather has curtailed our activities to a large extent.

In spite of a very encouraging list of newcomers, the trials were extremely poorly attended. Would-be champions, come forward!

A full fixture-list has been made for the 1st VI, including the popular tussle with Professor Johnston's VI. Matches are also arranged for the 2nd VI. There is a possibility of running the Inter-Hospitals Cup again, and a Hospital Mixed Doubles Tournament later this year.

Up to date we have played four matches. The 1st VI beat Middlesex Hospital 5–3 and London Hospital 7–1, but a weakened side narrowly lost to St. Mary's Hospital 4–5. The 2nd VI played their first match against Imperial College and lost all nine games.

The captain and secretary are K. Y. Khong and R. Freeman respectively.

It has been announced that R. Freeman and A. J. N. Starte have been selected to play in a match between the English Universities and the Scottish Universities at Leeds on July 7th.

Yours, etc.,

K. Y. KHONG.

MINUTE BOOKS.

To the Editor of the GAZETTE.

SIR,—The number of enquiries I have in the Wills Library for past and present minute books of the clubs and societies affiliated to the Clubs' Union, tempts me to ask if you could appeal to past and present secretaries to hand in their minute-books to me and I will keep them in safe custody and a good state of preservation until required by the officials of the various bodies.

Many of the old minute-books are missing, and it is almost certain that the reason is that they have never had a permanent home.

Yours, etc.,

GEORGE WINSTON (Wills Librarian).

"THIS SPECIALISM."

To the Editor of the GAZETTE.

SIR,—Those of us who listened to the speech of Mr. Tom Johnston on the radio, and especially that part of it which dealt with hospitals and the medical profession, were intrigued to learn that in connection with the maternity service, the service of specialist genealogists are to be at the disposal of patients gratuitously.

If it is proposed to regulate our future ancestors, I think the planners are going a bit too far.

Yours, *etc.*,

C. H. R. O'MOSOME.

"Night Must Fall"

"NIGHT MUST FALL" is almost melodrama, and, as such, it demands a high standard of acting from the principals to prevent it from appearing commonplace or even ludicrous. That an amateur company should choose this play was boldness itself, but that they should make a success of it was brilliance. No one will quarrel with me when I say that this success was largely due to Tony Brewin, both as the producer and as "Dan." His handling of this difficult part showed that he possesses a fine sense of the dramatic and a good control of his acting; it would have been easy to let this part "play the actor" and thus disturb the balance of the play, but even his violence had a delicate touch which made it the more sinister. Gillian Debenham, as Olivia Grayne, was also cast for a difficult part, one of great intensity wholly unrelieved by any lighter touch of comedy. Compared with Dan, Olivia is a colourless sort of person on the surface, though hidden fires of passion burn underneath this veneer of ordinariness. Miss Debenham managed to bring this character to life with remarkable skill, though it must be an unsatisfactory part for any actress to play.

Finally, one must mention Drucilla Covell as the hypochondriacal Mrs. Bramson, a clever study of crochety old-age; Joyce Taylor, as her cook, who provides most of the comedy by a rudeness which must be considered theatrical even in these days of servant shortage; and Michael Gilbert, as Hubert Laurie, whose fatuousness was on occasions perhaps too obvious to be genuine.

In view of the success of this production, it is hard for the players that they did not play to fuller houses. We hope to see more of this company in the near future.

J. D. L. R.

Sport

Swimming Club

GUY'S *v.* BISHOP'S STORTFORD COLLEGE.

(*June 2nd*, 1945.)

Result: Guy's won.

100 *yds. Free style.*—(1) B. M. Gray; (2) B.S.C.; (3) R. G. Iliffe; (4) B.S.C. (64 2/5 sec.)

60 *yds. Free-style.*—1, J. Keeling; 2, B.S.C.; 3, B. H. Pickard; 4, B.S.C.

40 *yds. Breast-stroke.*—1, B.S.C.; 2, D. J. Gray; 3, J. R. Waller; 4, B.S.C.

40 *yds. Back-stroke.*—1, J. Keeling; 2, B.M. Gray; 3, B.S.C.; 4, B.S.C. (26 3/5 sec.)

Dive.—1, J. Keeling; 2, B.S.C.; 3, D. J. Gray; 4, B.S.C.

Medley Relay.—1, Guy's; 2, B.S.C.

Free-style Relay.—1, Guy's; 2, B.S.C.

Polo.—Guy's, 4 goals; B.S.C., 2 goals.

Points: Guy's, 41; B.S.C., 20.

May 30.—Against Epsom College.—First, won; second, lost.

April 30.—Against Beckenham S.C.—Drew

R. G. I.

The Boat Club

The United Hospitals Regatta, rowed at Putney on Saturday, June 23rd, 1945, was in many ways one of several surprises, some more brilliant than others.

Five hospitals — St. Thomas's, Guy's, St. Bartholomew's, Middlesex and London — entered crews for the Eights race — the first three rowing in the first, and Middlesex and London rowing in the second heat.

The first heat was rowed against the tide—an original procedure for, at any rate, the spectators' benefit—and at the start by the "Crabtree," the order from the Surrey bank was St. Thomas's, Bart.'s and Guy's. Within the first thirty strokes Guy's led Bart.'s by two and a half lengths and St. Thomas's by a length. Guy's then took the middle water to avoid a stream of drift wood and, in doing so, allowed Bart.'s to draw over to the Middlesex bank, where the tide was slackest. From then on Bart.'s, having the advantage of slack water, gradually drew nearer Guy's, but they did not appear to present any serious

opposition. It was not until after the finish, when Guy's beat St. Thomas's by one and a half lengths, that they were surprised to hear that they had lost to Bart.'s by three feet.

However, as the afternoon wore on, the crew's morale was gradually raised by the four beating Middlesex by a length in the finals, and by a very gallant and amusing race between the rugger fours of Middlesex and Guy's, in which Middlesex won, although Guy's certainly caught more crabs.

In the first heat of the sculling races R. T. Lowein raced against Lever, of St. Thomas's, beating him easily by a clear distance; but in the finals J. Garson, also of St. Thomas's, was a more serious opponent to Lowein, and it seemed that the latter would be deprived of his 1943 title. However, after a brilliant start, giving him a length's lead, Lowein settled down comfortably to a hard row, in which, by virtue of his longer stroke and firm finish, he maintained that distance almost to the end, winning by three-quarters of a length. This was a very fine race and a good exhibition of sculling from both men.

In the finals of the Eights race, Middlesex beat Bart.'s by a half-length.

Results.— VIII, Middlesex; Coxless IV, Guy's; Sculls, Guy's (R. T. Lowein); Rugger IV, London.

Crews.—VIII: (Bow) D. G. Brett, C. C. Bull, C. H. Williams, J. Inskip, A. J. Crick, F. de Hamel, T. H. S. Burns (captain, U.H.B.C.), (stroke) R. T. Lowein (captain), (cox) A. A. Shotts.

IV: (Bow) R. T. Lowein, J. Inskip, T. H. S. Burns, (stroke) F. de Hamel.

Rugger IV: H. Goodge, A. Hutchinson, J. Knowles, (stroke) A. Shotts, (cox) T. H. S. Burns.

As a reminder the VIII will be going to Henley Regatta on July 7th.

Hospital Information, etc.

Pass List

CONJOINT BOARD.

PRE-MEDICAL EXAMINATION.

June, 1945.

Chemistry.

V. H. Freiberger — M. J. Smallcombe
L. F. Le Clus — P. H. Tucker
G. E. Moore

Physics.

D. G. Brett — L. F. Le Clus
L. P. Frank — M. J. Smallcombe
P. Griffiths — R. V. Warren

Elementary Biology.

V. H. Freiberger — H. G. de Jiminez
N. D. Glickman — G. E. Moore
A. E. Jacques — M. J. Smallcombe

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

May, 1945.

Pathology, Bacteriology and Forensic Medicine.

* D. J. Chapman.

* Has completed the examination.

Wanted

For filing in a library, reprint of paper by T. B. Layton, on "The Voluntary Hospital with a Medical School," published in *The Lancet* on December 9th, 1944.

Will any member of the Governors or Staff who has kept his copy and no longer requires it, kindly send it to the Editor?

Papers by Guy's Men

Leader, S. A. Dental and surgical plastics *Dental Gaz.*, 1945, ii, 454.

——— Reply to Dr. J. A. Saffit on the wear of acrylic teeth. *Ibid.*, 455.

Maizels, Montague. Intercellular plasma in the centrifugal erythrocytes of normal human blood. *Quart. J. Exp. Med.*, 1945, **33**, 12.

Pearson, R. S. Bruce. Steatorrhœa due to lymphatic obstruction. *Proc. Roy. Soc. Med.*, 1945, **38**, 385 (Sect. Med.).

Change of Address

T. D. Birtwistle, Surg.-Lt. (D.), R.N.V.R., H.M.S. *Patroller*, c/o G.P.O., London.

D. G. Dixon, Captain, R.A.M.C., 106 (Br.) General Hospital, B.L.A.

G. W. Garland (189693), F/O., R.A.F.(V.R.), 52, High Street, Bucks.

W. S. Lakeman, L.D.S., R.C.S., Westwater, Brundel Avenue, Bournemouth. (Tel.: Canford Cliffs, 1086.)

E. V. B. Widdowson, Surg.-Lt. Cmdr. (D.), R.N.V.R., Admiralty Medical Board, Queen Anne's Mansions, S.W.1.

Awards

R.R.C.

Miss Barbara Nockolds, Q.A.R.N.N.S. (Guy's, 1928–33).

O.B.E.

Miss Hope Lucas, Nursing Superintendent, Bowring and Lady Curzon Hospitals, Bangalore (Guy's, 1921–34).

Births

HEAP.—On 19th April, 1945, at Guy's Hospital, to Betty (née Griffith), wife of S/Ldr. A. M. Heap—a daughter (Susan Elizabeth.

Deaths

CHURTON TAYLOR.—At Southsea on June 2nd, 1945, Lily Elizabeth, beloved wife of Alan Churton Taylor, M.B.E., M.R.C.S., L.R.C.P., and mother of Pauline, John and Anthony, and sister of Eileen De Gale.

FERNANDEZ.—On June 5th, 1945, Thomas Fernandez, M.A., M.R.C.S., L.R.C.P., Sutton Court Road, Chiswick.

GAYER-ANDERSON.—On June 19th, 1945, Robert Greville Gayer-Anderson, M.R.C.S., L.R.C.P., retired Major, R.A.M.C.

McDERMOTT.—On June 26th, 1945, suddenly, at 23, River Court, Surbiton, Bryen McDermott, M.R.C.S., L.R.C.P.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1487 *21st July, 1945* *Ninepence*

PASSIM

THE European War brought with it many evils to Guy's in the form of air-raids, flying-bombs and the like; but, in addition, it introduced a more insidious evil than any of these, a spirit of disharmony between the teaching and nursing elements in the Hospital. That such a spirit exists cannot be denied; at present it does not present a danger to the smooth-running of the Hospital, for it has not reached any great proportions, but the fact that it is there is enough to warrant its exposure and dissection. Many will take us up on this supposed disharmony, we are sure, quoting examples in their own experience to disprove us—but if we are going to be strictly honest with ourselves we cannot close our eyes to this rift in our midst; and if we intend to make an honest attempt to correct it, we must first fully realise what we are trying to correct. We say that this evil is a product of the War and we believe this to be so, but by blaming the War we cannot thereby exonerate ourselves completely. True, the War has created unnatural and difficult conditions, but it is our duty to show our resilience by combating these conditions as best we can.

Guy's is a great teaching hospital, and a great teaching hospital has its foundations upon the harmony that exists beteen the nursing and teaching departments. As is so often the case where discord arises, the blame may be fairly equally divided between the two factions. Let us first give the ladies a chance to exonerate themselves; during the War the teaching facilities at Guy's have been so reduced that we now find ourselves in a position where the cases available are too few for the number of students to be taught. This inevitably means that the few wards left are overcrowded with students and that the pressure of this influx is brought to bear on a relatively small number of nurses. No one will deny that the presence of students in the ward adds materially to the amount of work that the nurses have to do and, under the present unnatural conditions, this pressure of work is doubly great. Then, again, the lack of domestic staff in the wards gives further work to the already overburdened nursing staff. To the sister of a ward the student only spells more work for her nursing staff, and so a feeling of resentment is liable to be felt against him.

Let us now examine the case from the man's point of view; their quarrel mainly is against the obstacles that are put in their way in the wards. Many sisters have reduced the times that students may be in the wards to a minimum and any infringement of these times is met with a certain degree of coldness. If the student is timorous he learns no medicine, and if he his resistant he earns the disapproval of the sister. He reasons that fundamentally this is a teaching hospital and that he has a right to see the patients as much as possible. Here lies the main cause for the discord; each party has its own point of view and each is right to a certain extent. The gap between these two extents, however, must be bridged by tolerance and thoughtfulness for a happy issue to result.

Criticism is useless unless it has a constructive corollary and, bearing this in mind, we make bold to suggest a solution to at least part of this problem.

The nurses are part of a teaching hospital and therefore must abide by the principles that this entails, and in so doing they will benefit themselves; if they are not prepared to acknowledge these principles they should train at a non-teaching hospital. The students should realise how much extra work the War has put upon the nurses and exercise thoughtfulness in the wards to lighten this burden; such little exercises as leaving beds tidy and putting away screens are no great hardship and are certainly a great help. Much can be accomplished by mutual co-operation, as has been discovered

in many wards of the Hospital already, and we hope that this may soon become more universal. We should be very glad for any reasoned correspondence on this subject, as we are sure that many of our points have been inadequately expressed and first-hand opinions would be of value.

WE would like to congratulate Mr. W. H. Ogilvie on his appointment as Vice-President of the Royal College of Surgeons.

WE would also like to congratulate Mr. Wass on his appointment as Hunterian Professor.

Guy's and the German War

BY P. M. F. BISHOP, D.M., *Medical Officer-in-Charge* (*E.M.S.*), *Guy's Hospital.*

THE principal theme which dominates this story is the air attack on London; this stands out stereoscopically against its background. The background, however, is a complex scene, moulded by the varying fortunes of the British people and their allies, and though, in retrospect, it has not been easy to judge the perspective, an effort has been made to recapture the capriciously changing moods which characterised the human response to the events of this chronicle.

I.—THE FIRST YEAR.

There is no doubt that the sense of apprehension was most marked as the curtain rose upon the first scene. The whole lay-out of the Sector scheme was based on the presumption that London would be immediately submitted to the most violent and concentrated air attack as soon as war was declared. As a sultry August drew to its close the forebodings of the Munich days of a year ago took shape like some monster of impending destruction. Digging the trenches in the Park,* filling the sandbags and placing them in position†, the preparations for evacuation, the completion of the plans to take up action stations, all led in a feverish *crescendo* to the receipt of the fateful "Clear Hospitals" telegram, and the evacuation on September 1st, 1939, of all but twenty-seven immobile patients by Green Line ambulance and train to Brighton. This was shortly followed by the exodus of staff, students and nurses to their base hospitals. We who remained at Guy's looked upon ourselves as a doomed garrison.‡ The scramble for the trenches and the undignified and precipitate descent to the basement of night-attired figures in gas-masks, in response to the War's first two air-raid warnings, left no doubt as to our feelings.

Though our ordeal was to be delayed for another year our suspicions were not easily lulled. The work of sandbagging went on; the first baby was born in the emergency maternity theatre in Salomon's Centre, the first operation performed in the emergency underground theatres. Guy's House stood empty and the administrative offices moved to Nuffield House. Air-raid rehearsals, ambulance practices, first-aid lectures, the reception of mock casualties and the gruelling training of the gas squad under Dr. Garrus occupied our time and thoughts. We carried gas-masks, some had *tin*

---

* The trenches were 280 feet long and required the excavation of 250 cubic feet of earth. Five thousand square feet of timber was used to line them and they were covered with a canopy of sections of a disused steel chimney, bisected vertically and weighing 10 tons. The entire process of digging, lining, roofing and blast-proofing with sandbags was completed in six days by student volunteers and Works Department experts.

† Twenty-two thousand sandbags were filled with 500 cubic yards of sand. One thousand five hundred lamps were sprayed with blue paint. Two thousand five hundred windows were blacked out with black paint or 1,600 yards of material and 300 dark blinds. Protective wire mesh was fitted to 200 windows. Members of the Works Department worked twelve to sixteen hours a day, and asked to be paid at ordinary rates, and not to be given the double pay to which they were entitled at trades union rates.

‡ Thirty medical officers, 120 students, 130 nurses and 100 members of the Female Administrative and Works Department Staff.

helmets, some wore E.M.S. armlets. Everyone was " whole-time " ; there was a wave of jingo-ism and war hysteria, a rush of sudden marriages. A great deal of attention was paid to maintaining morale. There was cricket in the Park with the Queen's Regiment,§ and open-air evening sing-songs at night. Concerts were organised at which Beatrice Lillie, Elisabeth Welch, Spurrell and Baker, or the Works Department " Crazy Gang " topped the bill. Tom Hills's " Starlets' Revue " began to take shape.

Gradually the plight of the neglected " civilian sick " and the prospective examinee began to dawn upon us. Out-patients re-opened and their numbers increased by geometrical progression ; ward admissions followed suit, and by October there were 130 in-patients ; rounds and informal lectures were organised ; students exhausted their tutors with demands to be taught. Autumn and winter and the black-out strangled with dank fingers the spirit of midsummer madness ; less was heard of the escapades at "Joyous Green." Grumbling and dissatisfaction with the E.M.S. contracts provided the chief topics of conversation ; many of the Staff accepted the " part-time offer " and returned to their practices. Part of Nuffield House re-opened ; students lost their billeting allowances. " Hitler's missed the bus," " Let's get back to normal," " Let's join the Services and do something " were the battle cries. Ambulance practices and A.R.P. began to pall and were maintained only with difficulty and unpopularity.

II.—THE BATTLE OF BRITAIN.

The scene changed ; Hitler's hordes poured through the Low Countries and into France. At first the comfortable fashion of complacency died hard ; " Passim " was faithfully recording the final flicker of the Maginot-minded, when it wrote on May 18th, 1940 : " It is therefore our duty at home to believe that the enemy are being drawn into an ever wider and deeper trap, so that ultimately she will become an unmanageable mass of dismembered segments." Then with sickening suddenness the sense of danger came upon us. This was no trap ; the " Battle of the Bulge " was lost ; the German tanks swept all before them ; Paris fell, the Channel Ports, Dunkirk. . . . The Battle of Britain was on.

Once again Guy's and the whole Kent sector were awake and seething with activity. Casualties were arriving from France after perilous, miraculous journeys. Mr. Atkins and his mobile surgical team hurried to Dover and helped to restore order where serious chaos might have reigned. Stories of the Fifth Column were told ; foreigners were interned ; in compliance with Government instructions aliens working at Guy's were no longer allowed to enter its precincts ; rumour and suspicion were rife ; lights mysteriously turned themselves on in conspicuous defiance of the black-out ; one could not move without showing an identity card ; stories were told of unheeding motorists shot by sentries. Bombs fell in Kent.

The feeling of emergency predominated over all others. Ambulance practices and air-raid rehearsals were frequent ; all was done to perfect every detail of the casualty reception organisation. Yet no one was satisfied ; everyone sought an opportunity to give a little better than his best. Volunteers flocked to offer their services ; parties to make bandages and surgical dressings were organised ; a group of skilled engineers worked far into the nights making precision tools urgently required by an aircraft factory. Every attempt was made to obtain work of vital national importance to occupy every spare minute.

The toil and sweat were there, the blood and tears were to come. Once again a sultry summer brought with it the apprehension of imminent danger, this time from invasion as well as bombardment. Though we at Guy's were still to experience enemy activity, those whose business took them into the Sector had exciting tales to tell of dog-fights, vapour trails and machine-gun bullets. Air-raid alerts became more frequent, and " nuisance raids," as we called them (though to the Germans they were obviously armed reconnaisances), began to disturb our sleep.

There were persistent rumours that the E.M.S. was to be merged with the medical services of the three fighting forces, and that it would have a green uniform. Indeed, Sector Matrons had already begun to appear in theirs.

---

§ A company of the Queen's Regiment was billeted in the Imperial Hotel, in St. Thomas's Street, and it was rumoured that they had been put there to protect the Hospital from being stormed by panic-stricken citizens in an air-raid !

III.—THE "BLITZ."

On September 7th the blow was struck at last. High in the clear sky of a glorious summer evening three hundred and fifty German bombers and fighters flew up he Thames and dropped their bombs on the London Docks. As the evening shadows lengthened and the glow of the fires on the eastern horizon matched the sunset in the west, it seemed certain that the bombers would return, and throughout the hours of darkness we were tested. (The "alert" sounded at 8 p.m. and the "all clear" at 5.35 a.m.) A message from Region told us to expect casualties from the dock area; a school building said to have contained a thousand people bombed out in the afternoon raid had been hit. We promised to take two hundred casualties if they could be brought up by the River Emergency Service. They never arrived because the fires from the south bank made the river impassable, but while we waited for them we ourselves were not unoccupied. After admitting seventy-five casualties from our own district, we decided to evacuate thirty-five patients to make room for the dockland convoy. It was perhaps as well it did not come; our baptism had been fairly thorough. Standing on the roof at dawn and seeing London encircled by flames one could only feel a profound sensation of relief that after so much rehearsal and preparation the organisation had stood up to the real thing. It was true we had not yet been hit; we had not long to wait.

Night after night the bombers returned and on twenty-five consecutive nights from September 7th Guy's admitted casualties. On September 8th, at 8.46 p.m.,* three incendiaries fell in the Hospital—one on the roof of the Eye Ward theatre, one in the Park and one on the roof of the Nurses' Home. All were extinguished with ease and zest. On September 10th an incendiary penetrated the roof of the Matron's House.

On September 15th the main topics of conversation after the nine o'clock news were the day's bag of 185 German planes—a record up to date—and a stupid rumour that Haw-Haw had promised that Guy's would be bombed that night. At 9.55 p.m. a stick of three 50-kg. high explosive bombs straddled the Hospital. One penetrated the dome above the main staircase of Hunt's House and burst at the level of the third floor, causing considerable damage from blast and bomb fragments to the Clinical Wards and the Children's Ward. Both these wards and Mary Ward on the floor below had been emptied in the course of the previous week, during which night bombing had been intense. The main staircase was completely demolished and collapsed in a heap of rubble which reached from the ground to the first floor level and blocked the entrance to the building. Both lifts were destroyed. Mains from the water storage tanks in the tower were fractured and cascades of water poured down upon the debris. The electric, gas and steam mains were cut, and gas and steam escaped into the building. Fire broke out in the debris of the Clinical Research laboratory on the third floor and was finally extinguished by the fire squad using hand buckets and tin helmets filled with water. Mr. E. R. Davies, a junior medical officer, received a severe scalp wound and a fractured skull in a small room on the third floor and had to be lowered from the window and carried down a fire-escape ladder on the back of a fireman. Sixty patients were carried in twenty-three minutes from the first two floors down fire-escape staircases on the outside of the building and bedded down in the Out-patient Hall. Use was made of a specially constructed chute which had been erected a few days before in case it should be necessary to use this means of exit. Though there were about 230 people in the building at the time it was struck Mr. Davies was the only casualty.

The second bomb penetrated the basement of Hunt's House and burst in the coal-cellar. Visiting bomb experts warned us that this bomb was in all probability unexploded, and a squad of students, led by Mr. J. R. D. Williams, volunteered to dig out the coal and expose the bomb or to look for evidence of its fragmentation. Their efforts made it certain that the bomb had in fact exploded.

The third bomb fell in the Works Department yard. Gas and water-mains were fractured and the basement of Tabard House, which was used as a sleeping shelter for the maids, was flooded and had to be evacuated. But the most worrying feature was the threat to the essential services of the Hospital caused by the flooding of the engine-room; this menace was overcome just in time, but not before the chequer plates in front of the boilers were awash. This unpleasant complication occurred on a

---

* Much of the information contained in this account comes from the Incident Officer's Log kept by Nelson Burgess.

number of other occasions later in the " blitz " owing to the difficulty of pumping out the vast quantities of water used to extinguish fires in the neighbourhood of the Hospital.

An hour later two bombs fell—one in the George Inn Yard, which blew out windows in the Old Pathology building and shattered the glass roof of the Conservation Room ; the other fractured a gas main in Talbot Yard and was thought to be an unexploded bomb. A blast apron of sandbags was therefore hurriedly constructed in the Works Department, principally to protect the engine-room. Despite its proximity to the bomb the laundry continued to function. A week later the bomb was concluded to have exploded.

Dawn and the " all clear " were welcome that next morning. The night had been crowded and exciting, but no one lingered to discuss its events ; the chance to sleep was more attractive. Standing on the roof to watch the dawn and the fires, once again the sensation was of relief and thankfulness that so little injury could accompany so much destruction, and of admiration for the resourcefulness, energy and bravery of nurses, students and Works Department staff.

The " blitz " continued. On seventy-one days of the seven months while it lasted casualties were received in the Hospital ; the total number was 1,823, of which 939 were admitted ; on five occasions the daily total exceeded one hundred. On ten nights the Hospital was involved in incidents either on its own premises or so close as to require that some emergency steps should be taken. Water, gas and electricity (A.C., but never the Hospital's own D.C.) all failed from time to time. For over a week the only drinking water was brought up from the country in milk-cans, and a small dam set up in the Park and filled with home-chlorinated water supplied all other needs. Emergency paraffin stoves had on occasions to be pressed into service to aid in the ward cooking. So far as possible everyone slept in a basement, not because it was safer, but because it was a little less noisy. It was soon recognised that lack of sleep was the chief enemy of stamina and morale. The work of the Hospital was in general adapted to 48-hour shifts and people were encouraged to take their off-duty periods outside London ; in response to an appeal, offers of hospitality for these off-duty periods came from all over the country.

The loss of the staircase in Hunt's House was a serious handicap as regards ward accommodation ; Dorcas and Martha, in the Surgical Block, had to be re-occupied and the hall of the Massage Department was converted into a ward ; eighteen beds were set up in the northern end of the Out-patient Hall, and this became the main Casualty Reception Ward and was later christened " Hilton " at Sir Arthur Hurst's suggestion. The limited accommodation made it imperative to evacuate as many air-raid casualties as possible to base hospitals by midday on the morning following a raid, and at one time daily convoys were the rule.

On the night of December 29th the City of London was largely destroyed by fire. Guy's, on the fringe of this fire, was nearly surrounded by an inferno of blazing warehouses, the flames from which destroyed the College and the Deep Therapy Department.* In contrast to these locked and unattended buildings soon to be enveloped in a sea of fire Guy's remained largely undamaged, though thirty incendiaries fell on the Hospital itself and serious fires were started in Doyle's House, the Externs' Room and the Artificial Sunlight Department. There is no doubt that but for the initiative of the students and Works Department staff large areas of the Hospital would have been destroyed, and it is unlikely that it would have been able to function for many months to come.

But in addition to this ordeal by fire a stick of three 50-kg. high explosive bombs fell on the Hospital at 7.30 p.m. One demolished part of the east wing of Guy's House and patients in Dorcas had a lucky escape. The second penetrated the subway beneath the Guy's Shop and the bakery. Blast wrecked the Linen Stores, the basement of the Massage Department and a small mess-room in the subway, the occupants of which were trapped for a short time ; four of them suffered minor casualties. The blast extended as far as a locker room under the Nurses' Home and blew up the floor of Martha Ward, turning a piano upside down ; no patient was injured. The third bomb penetrated through the wall of the Dental Department in White Hart Yard, causing much damage to windows and to the basement of the Hostel from blast.

---

* Owing to the intensity of the surrounding conflagration the police eventually ordered the complete evacuation of the Hospital. Only twenty people holding key positions remained behind.

In the New Year the intensity of the bombardment diminished to some extent, though on February 17th a bomb fell on a large public shelter in Stainer Street Archway under London Bridge Station. Eighty-one casualties were admitted and sixty-three people were killed; many were drowned owing to a fractured water main causing the floor of the shelter to become flooded. On March 8th two bombs fell in the Hospital—one just in front of the Superintendent's House, one in the western quadrangle of Guy's House. Both were thought to be unexploded and all the buildings in the Front Quadrangle and Guy's House were evacuated and cordoned off for over a week. The second bomb was, in fact, unexploded and was removed by a bomb disposal squad.

On April 16th the Hospital suffered its last and most tragic loss. At 2.20 a.m. a canister of incendiaries fell on the Hospital. A fire started in the roof of the Nurses' Home and was troublesome to deal with. In the meantime an incendiary was smouldering in the roof of the Court Room. By the time it was discovered the fire had already taken such hold that it could not be controlled with stirrup-pumps and buckets. It was not until 5 a.m. that a fire-engine arrived (from West Ham); even then no water could be obtained from the hydrants, and it was 9 a.m. before the fire was eventually extinguished. Before the roof of the building collapsed everything movable was carried out of it by students and others.

On the two final terror nights of April 20th and May 10th the Hospital was lucky to escape damage. A 1,000-kg. bomb fell on the bombed-out site immediately behind where the "Ship and Shovel" had been, but fortunately the Hospital received no more than a severe shaking.

So ended the "Blitz." That it was a period of strain every citizen of London would agree, but perhaps it submitted certain classes of people working in hospitals to a rather considerable strain. All-night work was the rule rather than the exception, but yet the routine work of the Hospital had to be dealt with during the day-time as well, and in exceptionally difficult circumstances requiring good temper, initiative and a *flair* for improvisation. Those especially affected were the senior members of the nursing staff (such as office sisters and ward sisters), the staff of the administrative offices, works department staff, kitchen staff and the students. No praise can be too high for the invaluable service these people rendered to the Hospital at this time.

Here I would like to pay my personal tribute to three people, The first is Mr. V. E. Lloyd, at that time in charge of the arrangements for casualty reception. He was calm, efficient and cheerful. His friendly approach to all those who worked under him guaranteed their staunch loyalty to him. To me he was a pillar of strength, and I shall never forget the encouragement and help he gave me. The second is Professor Ryle, who arrived shortly before the "Blitz" and remained whole-time E.M.S. physician throughout it. On many occasions his foresight was almost prophetic; both medical officers and students learnt much from his medical teaching and he paid considerable attention to occupying their leisure moments with debates, discussions and musical recitals in the organisation of which he played a prominent part. To me personally he gave much good advice and friendly help. The third is Mr. Atkins, who was responsible for the surgical organisation of the Hospital. Not only did he build up a first-class organisation for the surgical treatment of air-raid casualties and set a high standard which was most ably maintained during the flying-bomb and rocket period by Mr. Wass and Mr. Kilpatrick, but he projected his enthusiasm and keenness to all who worked with him. His loyalty and helpfulness to me on so many occasions during this difficult time cemented our already long-standing friendship.

IV.—THE YEARS BETWEEN.

The years 1941 to 1944 must be telescoped because this is a story of London. The scene shifted to North Africa, to Russia, to Singapore, the Phillipines, Java, Borneo, Australia, Burma, and back again to Tripoli, Sicily, Italy and Russia.

This does not mean that London could take immunity for granted. Until well on in 1943 invasion was an ever-present possibility and the Home Guard was a prominent feature of the Londoner's life. Even Guy's had its own Home Guard platoon. From time to time gas featured prominently in the precautionary activities of the Hospital, and there was a time when from 11 a.m. to 11.15 a.m. each Wednesday morning everyone donned his gas-mask and carried on with his work. Air-raid rehearsals continued and became less popular and more infrequent.

The first scene of this Act—the ebb of the tide of war—was played against a sombre back-cloth. The war news was constantly gloomy—the Russian retreat; the loss of

vast areas of the Pacific; Rommel's threat to the Suez Canal. The scene at home was one of shortage and austerity. There was shortage of civilian doctors and house-officers owing to the great demands of the Services, shortage of nurses, shortage of domestic staff. There was shortage of food, and the Ex-Patients' Guild launched the "Grow Greens for Guy's" campaign, shortage of drugs, and the dispensers planted belladonna and hyocyamus in the Park; shortage of paper, and all the In-patient Reports up to 1900 fell a victim to the intensive paper salvage drive. There was shortage of fuel, and even some of the residents of Nuffield House had a bath only once a week. There was a shortage of clothing, shortage of milk, shortage of leisure, shortage of temper.

The second scene depicted Planning and Reconstruction. More and more attention was paid to teaching and more and more straws were placed on the sagging backs on the few remaining camels of the teaching staff. More attention was paid to the civilian sick, and gradually, though, some thought, too slowly, more beds were made available to meet the rapidly growing demands of these patient and uncomplaining sufferers. The number of Out-patients increased, and an appointment system was introduced, and secretarial assistance provided for the overworked consultant at Out-patients'. An arrangement for the immediate priority treatment of all patients occupying posts essential to the war effort sent up to the Surgery or Out-patient department was put into practice.

The Wildernesse was opened to provide 120 extra beds and to make up for the losses Guy's had suffered during the "Blitz." It received so much help and sympathy from our American allies, through "Bundles-for-Britain," who, among other things, provided a completely new deep X-ray plant, that this country annexe was named "Guy's U.S.A. Hospital." The acquisition of this famous country club was made possible through the friendly co-operation and generosity of Mr. Foster, the owner, who charged us an annual rent of £1.

The York Clinic was opened, first, to relieve the acute shortage of beds in the Hospital itself and, finally, to assume its originally intended responsibility of dealing with pyschiatric patients, and into its beds were admitted large numbers of psychiatric casualties from the battlefields of Normandy.

Medical post-war planning received serious consideration. The Medical Planning Commission, the Beveridge Report, the Rushcliffe Report, the Hetherington Report, and the Goodenough Report had their counterpart in the Joint Post-War Planning Committee of the Guy's governors and staff. The "Committee Stage" had been reached! By the "Let's-get-on-with-the-War" group these deliberations were thought to be premature; by the cynics they were regarded as sheer crystal-gazing. Nevertheless something concrete was achieved. Mr. Alner Hall, the new architect, produced plans for the new Guy's, to cost at least £2,000,000 and to provide a thousand beds, new administrative offices and a new College with much more spacious residential and recreational accommodation.

Like some Sword of Damocles hanging more and more menacingly over these scenes of retrenchment and reconstruction was the ever-present threat first, of invasion, then of renewed aerial bombardment, and, finally, of attack by long-range weapons. The explosion in the Borough of a 1,000-kg. delayed action bomb whose arrival in the "Blitz" had been unnoticed, temporarily dispelled all feelings of complacency on June 6th, 1942. Forty-nine casualties were received at the Hospital, and not so efficiently received as they would have been during the "Blitz." Rumours of rockets were whispered as early as Christmas, 1943. By the spring of 1944 the Pas-de-Calais featured prominently in the news. The opening of the Second Front, which seemed to have been so long delayed, was almost certain to bring with it a further test of the endurance of the civilian population of this island. In the meantime there had already been a renewal of enemy activity directed against London.

V.—THE "FEBRUARY RAIDS."

In February, 1944, the Germans staged another air attack on London. The tactics were different from those of the "Blitz." The raids were short—they lasted under an hour—and concentrated. About seventy light bombers were sent over at a time. There were many reasons for expecting that the main danger would be from fire. The Germans were known to have comparatively few heavy bombers. In the "Blitz" they had, on the whole, done far more damage with incendiaries than with high explosive bombs. We had been given to understand that our own new phosphorus bombs had been devastating in Cologne and other German cities.

It was the fear of fire which dictated the tactics adopted at Guy's. Conditions were different from the days of 1940. The staircase and one lift had been repaired in Hunt's House and the upper floors were being used. Much of the roof was patched up with first-aid repairs ; as for the rest it consisted of eaves which were extremely difficult to make fire-proof. The number of people residing in the Hospital was much smaller than in the "Blitz," and the number of students on the air-raid rota considerably so. The danger, then, as I conceived it—and I must take the responsibility for any arrangements which were unpopular at the time—was that three or four incendiaries should start simultaneous and separate fires in Hunt's House, and that our comparatively depleted air-raid staff would have to deal with the fires and the evacuation of bed-ridden patients at the same time. The solution was a clumsy one, but I could see no alternative. It was to evacuate the upper floor wards as soon as an alert was sounded or the progress of the raid seemed to indicate imminent danger. This evacuation was not easy ; there was only one lift and it took a minute and a half to descend from the second to the basement floor, and it would carry only one stretcher or two chairs. Obviously the main evacuation must be by the staircase. Even the toughest rugger forward was a bit out of breath after carrying three stretchers downstairs, and there were only eighteen air-raid rota students, and two were needed to each stretcher. Time, moreover, was an important factor ; twenty minutes was the limit of safety. Instructions were given that as few stretcher cases as possible were to be admitted to wards above the first floor. A ward-evacuation clerk was appointed to do a round each evening before black-out and to make a list of the number of stretcher cases that would have to be moved ; ward ushers and a lift-boy were also detailed to supervise the orderly evacuation of the wards. Stretcher-bearers carried patients only as far as the subway ; they were then conveyed on trolleys to the basement of the Massage department or the new Pathology building, where emergency wards were equipped for their reception. The trolley-pushing was done by Miss Addiscott and volunteers working under her supervision. Once evacuated in this way the patients did not return until the morning.

These cumbersome precautions proved quite unnecessary. The February raids turned out to be mainly high explosive attacks, and the area surrounding Guy's suffered comparatively little. We received only twenty-three casualties throughout this period, thirteen of them being admitted on the night of February 20th.

VI.—THE FLYING BOMBS.

At the beginning of this phase we were, on the whole, taken by surprise. We had certainly expected something unpleasant to happen shortly before or shortly after D-Day, but, of course, we didn't expect flying-bombs. Indeed, we didn't know what they were when they first arrived ; nor did we know how to cope with them, and here we were in good company, for the Government's order to shoot them down even in the heart of London brought us in over three hundred casualties in the first week. But we both soon got the measure of this attack ; the Government stopped shooting in the built-up areas, and caught them on the periphery, and we realised that the important thing was to watch for them coming. In a fortnight after their first appearance we had a rota of students, a couple at a time, for an hour at a time, on duty on the roof of Salomon's Centre throughout all daylight alerts. Whenever a flying-bomb was actually seen to approach in our immediate direction a warning was sounded throughout the Hospital by these intrepid watchers ; it is unnecessary to describe the process of taking cover to any flying-bomb *habitué* ; it required little tuition. For the bed-ridden patient there was little to be done ; the warning was too short to ensure his safety, and all one could do was to reassure him as far as possible by carrying on with one's own work despite the sound of klaxons or the grinding *crescendo* of the infernal machines themselves. The bearing of the ward sisters and nurses on duty was quite admirable from this point of view. It is noteworthy that the Dental Department volunteered to take over two of the five and a half days in the week on this look-out rota ; it was not unnatural that people who lived in a glass house should be slightly apprehensive about flying-bombs.

Though the Hospital itself suffered no damage beyond a few panes of glass from the flying-bomb attacks, reference to the Incident Chart* will show that a number of flying-bombs fell quite near, and it was not long after the attack started that we were busy with casualties. On June 16th, for ihstance, we received 131 casualties. On thirty-one days between June 16th and August 20th casualties were received, the total number being 791. This entailed a considerable amount of work for the surgical teams, and much of it was done at night. Once again lack of sleep became a prominent symptom ;

***Owing to M. of I. censorship for security reasons, the Incident Chart cannot be published until a later issue.—Ed.**

many people sought basement shelter again at night, for basements really did seem safe from this form of attack. Unfortunately there was not nearly enough basement accommodation in the Hospital to make it feasible to nurse the patients permanently in it, and this was done only in the case of the children, who were evacuated from Diplock to the Lecture-Demonstration theatre in the basement of the Medical School throughout this period.

VII.—THE ROCKETS.

There was a lull of about six weeks before the rockets began. At last the Germans had invented a missile against which no precautions whatsoever could be taken. This was a great relief to everyone : there was to be no more of the ducking or diving under tables that characterised the flying-bomb era. By this time the demands on the civilian sick beds were great and, despite the rockets, the Hospital was always very full.

Casualties were received on eighteen occasions between October 26th, 1944, and March 7th, 1945 ; the total number was 452. On two occasions more than one hundred were admitted. One of these was an incident at a factory 230 yards from the Hospital ; within ten minutes of the rocket falling the first casualty was received, and within twenty minutes after that 90 casualties had entered the surgery. Instructions were then sent to the Incident Officer to switch ambulances to another hospital, as we had already exceeded our official " switch-figure " of 75, but, by the time these instructions could be implemented, another 83 casualties had been received. The organisation for casualty reception was on this occasion considerably strained owing to the number of casualties and the rate at which they arrived at the Hospital. Four surgical teams were kept busy operating for eight hours. In addition, the Hospital itself suffered considerable damage from blast and over 250 windows were smashed.

Throughout the flying-bomb and rocket period the surgical treatment of the casualties was maintained at a very high standard. For this Mr. Wass and Mr. Kilpatrick were almost entirely responsible. I should like here to pay tribute to their efficiency, their energy and their mature judgment. These two men have certainly rendered exceptionally fine service to their country throughout the German war.

One other section of the Hospital organisation must be mentioned, and that is the nursing staff. Apart from the initiative and resourcefulness with which they have on innumerable occasions coped with the most trying circumstances, by their example and bearing in times of danger they have given encouragement, comfort and reassurance to their patients, which I know has earned them the deepest gratitude. To see morale at its highest one had only to enter Sister Falwasser's or Sister Harrison's wards during a period of bombardment. This truly amazing exhibition of all the finest qualities of nursing was not confined to a few individuals, but was displayed by the whole of the nursing staff, and was very largely due to the inspiration and calm dignity of one remarkable woman—Sister Wittrick. No one is better qualified than I am to know how thoroughly well deserved is her recent honour of the M.B.E.

VIII.—CONCLUSION.

And so Guy's has come through the War, not entirely unscathed, but bearing honourable scars ; 9 high explosive bombs and about 70 incendiaries have fallen in its precincts. It has dealt with casualties on 134 occasions, the total number being 3,089. In addition to this it has dealt with large numbers of Service sick, besides sending out mobile surgical teams and nurses, as well as students to the shelling of Dover, and to the South Coast immediately after D-Day, and even to Belsen Camp. We can justly claim that Guy's has served its purpose as an E.M.S. Hospital in war-time.

Obituary

NORA LUCY KYTE (of the X-Ray Department, 1934–1945) died suddenly in Bright Ward on Wednesday, July 4th, 1945.

She entered Guy's as a radiography student in 1929. She had been working in the X-Ray Department at the Miller Hospital for a short time prior to that and her great interest in this work brought her to Guy's to take up the training in earnest. As a student she showed the keenness and ability that persisted throughout her career. Qualifying in 1930, for four years she gave her services to the Middlesex Hospital, but such was her interest in and affection for her training school that she returned to Guy's in 1934, on whose staff she remained until her untimely death.

She will be best remembered for her continued good humour and willingness to help, often in most trying conditions of which the war years were no exception. She was always interested in and most helpful to those seeking knowledge of the intricacies of radiology, and she had a grasp and knowledge of this subject possessed by few in her profession.

She will be well missed by her colleagues with whom she was one of the most popular and congenial of companions. R. M. S.

Correspondence

GUY'S HOSPITAL LADIES' ASSOCIATION.

To the Editor of the GAZETTE.

SIR,—Guy's Hospital Ladies' Association, after nearly six years of war during which it has carried on under great difficulties, is now faced with the problem of finding new executive officers.

It would be disastrous if, after years of invaluable work, the Association should be suspended for lack of officers. Guy's Hospital Ladies' Association is the oldest and largest connected with any London teaching hospital and its work is indispensable. We have a large number of members and sewing members who are more than willing to carry on and, if you can see your way clear to make known our difficulties, we shall, I feel sure, be able to continue the good work.

The Committee feel that it would get a readier response to this appeal if each executive officer had an assistant.

The vacancies for which volunteers are urgently required are as follows :—Assistant Hon. Secretary; Hon. Treasurer; Assistant Hon. Treasurer; and Assistant Hon. Organiser of Work.

Any suggestions or offers of help should be sent to Mrs. Marston, Hon. Secretary, 80, Harley House, N.W.1.

Yours, etc.,

M. EBBISHAM,

41, Upper Brook Street, W.1. Chairman, Guy's Hospital Ladies' Association.

DOMESTIC WORKERS AT GUY'S.

To the Editor of the GAZETTE.

SIR,—It is with keen interest that I hear of the advent of women from the prisons as domestic workers at Guy's. A little help is worth mountains of sympathy. This is the first concrete effort from any of the hospitals to produce help for for the harassed and overworked nurses, and it is due to the ingenious and active mind of Miss MacManus.

The Nursing Staff has held the "domestic baby" long enough, and we would like to hear a louder (much overdue) outcry from the Hospital authorities collectively.

The General Nursing Council, in order to improve the status of the nurse, have spent much time and paper in preparing a new syllabus of lectures and classes for probationers. It appears that they have put the cart before the horse. They would have been better employed in demanding from the Ministry of Labour the supply of domestic workers so necessary to maintain the urgent work of our hospitals. Until these workers are available the nurses will lack both the time and energy required for additional lectures.

We much appreciate the recommendations of the Rushcliffe Report and the increase in our salaries, but in view of the present high cost of living should not the hospitals offer a war bonus? Many of us have to save in order to provide for ill-health and old age.

We remember the selfless devotion shown in the past by members of the nursing profession. We do not forget the time when ward sisters would be left exhausted and overwrought by a minimum of 12½ hours duty daily. The present generation

honours their memory, but it is not prepared to accept unfair conditions without question and who shall say it is wrong ?

" What is this life if, full of care,
We have no time to stand and stare ? "

In an article in last Sunday's *Observer* the industrial correspondent mentioned those horrid words " Trade Union " as the only answer to these and other difficulties. I hope we can be saved before it is too late. Is the problem beyond the Hospital authorities, the General Nursing Council and the College of Nursing ? Must it be left to State control and trade unions ?

We want 32,000 nurses

Patients are waiting for treatment meanwhile !

It is essential that the hospitals should have an answer to the criticisms and accusations which, appearing with increasing frequency in the daily Press, do much to deter the would-be nurse from entering the profession.

Yours, etc.,
M. S. GRIFFITH
(Ex-Sister Lydia).

Guy's U.S.A. Hospital, Seal, Sevenoaks.

REFRESHER COURSES.

To the Editor of the GAZETTE.

SIR,—There seems to be a considerable feeling, particularly among younger practitioners in the Forces, that their clinical senses will have become atrophic after perhaps prolonged periods of administrative duties. I feel that this is being somewhat pessimistic, and recall in this connection a dictum of Dr. A. P. Beddard. He stated that his experience of many years of consulting practice showed him that most of the difficulties in which he found general practitioners from time to time were due, not to lack of knowledge or clinical acumen, but to lack of proper case-taking and clinical examination. Now these, Sir, are things which when once learnt are never forgotten ; my chief impression of Service duties after a period of general practice is of *the adaptability that is required in constantly changing circumstances, and that this* training will stand a man in good stead on going into practice. There is no compulsion on a young man to go into isolated and independent practice, and it seems probable that after whatever refresher courses are possible there will be no difficulty in practising as an assistant or partner to an experienced practitioner, and with this backing and with ready access to books and consultants the new general practitioner should very soon find his feet.

Yours, etc.,

C. W. MARSHALL.

C.M.F.

Sport

The Boat Club

Henley Royal Regatta—the first for six years—was organised for Saturday, July 7th, 1945, as a one-day regatta with races for all comers—eights, schools' eights and sculls.

Although the regatta was on a somewhat reduced scale, it lacked none of the pre-war brilliance and spirit.

Guy's were unfortunate in having to make a last-minute alteration in their crew, the situation being summed up very typically by a newspaper correspondent, who wrote : " Cox Shotts one of the eight." R. T. Lowein was unable to row following an ankle injury the day before the race ; instead, F. de Hamel stroked the eight with A. Shotts at No. 2, and A. Fooks taking his place as cox.

In Heat II of the all-comers' race Guy's took the Berks station ; Thames were in the middle ; and Pembroke on the Bucks station. With an altered crew the eight's best chance of winning was to get a lead within the first thirty strokes with a high rate of striking, and this stroke was able to do, being backed up magnificently by the rest of the crew.

For a while Guy's led Thames by a quarter-length and Pembroke by about a length, but by the half-mile post Thames gradually drew away from Guy's, and the latter were never quite able to retrieve the lost distance. The race finished with Thames winning by one and three-quarter lengths in 4 min. 56 sec.; Guy's, second ; and Pembroke, a length down on Guy's.

Crew.—D. G. Brett (bow), A. A. Shotts, C. H. Williams, C. C. Bull, A. F. Crick, J. A. Inskip, T. H. S. Burns, F. de Hamel (stroke), A. Fooks (cox).

Sailing Club

The year 1945 has been a record one for the sailing club. Its membership has risen to 45 ;

the club has reached its "coming of age"; and its members have supplied the United Hospitals Sailing Club with its hon. secretary, hon. racing secretary and, more recently, with its hon. assistant bo'sun. Also it has supplied a greater number of men to crew in United Hospital matches than any other hospital, and so far is leading (tied with St. Mary's) in the Inter-Hospital Sailing Competition. Below is a table showing the positions of the *main* hospitals in the competition *to date* —

Points: Six for a 1st; five for a 2nd, etc.

Points *added* after each race.

Hospital.	1st	2nd	3rd	4th	5th
Guy's	6	11	17	23	—
St. Mary's ..	5	11	17	23	—
St. Thomas's ..	5	10	16	22	—
Royal Dental ..	4	8	12	—	—
King's	5	5	8	8	13
Royal Free ..	3	8	8	12	16
London	3	4	7	—	—

N.B.—By the end of the season each hospital will have sailed nine time, and against each opponent three to four times.

Representing Guy's in the Inter-Hospital matches have been D. J. Reid (hon. secretary), G. B. Elphicke (hon. treasurer), D. J. Murch, and R. Lowein.

So far the U.H.S.C. has sailed as a team against Oxford University and Cambridge University, both at home and away.

Oxford were well beaten at Hammersmith and by a small margin at Oxford. With the "light blues" the club was not quite so fortunate, as although they were beaten on the Thames, they outsailed the Hospitals in the return match at Cambridge.

Reid, Elphicke, Murch and Wright were in the teams in these matches.

Further fixtures include matches against Minima Sailing Club (Surbiton), London Corinthian Sailing Club, and the Royal Ocean Racing Club, all of which should prove exciting.

Hospital Information, etc.

Notice

RUGBY JERSEYS WANTED.

Great difficulty is being experienced in obtaining Rugby jerseys with the Hospital colours. If any Guy's men could help by sending their Guy's jersey, the same would be most welcome. Please forward to:—Mr. H. L. Kirby, Guy's Hospital Athletic Ground, Brockley Rise, Honor Oak Park, S.E.22.

Pass List

UNIVERSITY OF CAMBRIDGE.
FINAL M.B. EXAMINATION.
Easter Term, 1945.
PART I.
Surgery, Midwifery and Gynæcology.

J. C. Bayliss — C. H. Kinder
J. E. Blundell — M. W. P. Ward
E. B. Gethen Smith — W. B. Webb

UNIVERSITY OF CAMBRIDGE.
M.B., B.Ch.,
FINAL EXAMINATION.
Easter Term, 1945.
PART II.
Principles and Practice of Physic, Pathology and Pharmacology.

R. A. Green — M. G. Thorne
C. H. Kinder

UNIVERSITY OF LONDON.
THIRD (M.B., B.S.) EXAMINATION FOR MEDICAL DEGREES.
April, 1945.
Pass.

N. J. Bloch — J. N. Hunt
M. J. Blunt — W. R. Lee
A. A. Cashmore — N. P. W. Littler, B.Sc.
D. Davies — R. G. Walton

Supplementary Pass List.
PART I.

S. Balfour-Lynn — W. E. D. Evans
A. J. Beale — W. P. Gurassa
L. W. Bowen — F. L. Jackson
P. E. Brown — J. Luder
J. Candy — I. A. H. Munro
J. F. Cleobury — C. R. Neve
P. Coling — R. Owen
J. C. Crook — R. A. Parker
D. J. Dennison — C. S. Shaw
J. R. Dickson — B. E. R. Symonds
H. G. Dixon — G. I. Tewfik

PART II.

K. H. Chin — J. D. Wallace
T. J. Jones

PART III.

L. W. Bowen — D. O'Keefe
S. Davis — J. M. Pugh
G. Forrester — C. G. Roberts
J. O. Kelsey — J. F. Shaw
P. R. Montgomery — F. R. M. Young
P. F. New

UNIVERSITY OF OXFORD.
B.M., B.Ch.
April, 1945.

SECOND EXAMINATION.
General Pathology and Bacteriology.

R. A. Bruce — D. C. Turk
B. V. McEvedy — D. P. Winstanley

SECOND EXAMINATION.
March, 1945.
Special and Clinical Pathology.
J. N. Micklem.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.R.C.S.
FINAL EXAMINATION.
June, 1945.
A. H. Harvie

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
L.D.S.
FINAL EXAMINATION.
June, 1945.
PART I.—Surgery.

S. J. Bell — G. R. M. Mote
R. A. C. Dove — I. D. L. Thomson
M. E. P. Easton — B. Wotton
G. B. Elphicke

PART II.—Dental Surgery.

D. A. Barr — M. C. Hudson
J. E. De Bondt — K. M. Little
R. A. C. Dove — G. A. Morrant
J. E. Dyke

Prize Awards

GUY'S HOSPITAL DENTAL SCHOOL.
June, 1945.

NEWLAND PEDLEY MEDAL AND PRIZE.
D. A. Barr

FINAL YEAR PRIZE.
G. A. Morrant } bracketed equal
J. D. Rumble }

GUY'S HOSPITAL MEDICAL SCHOOL.

PRIZE EXAMINATIONS, 1945.

Beaney Prize in Pathology.

Monday, Sept. 3rd.—10 a.m.–1 p.m. Paper. Date of Practical and/or Viva voce Examination will be announced later.

Leonard Lubbock Prize in Clinical Pathology.

Tuesday, Sept. 4th.—10 a.m.–1 p.m. Paper 2 p.m.–5 p.m. Practical and Viva voce.

Golding Bird Medal and Prize in Bacteriology.

Friday, Sept. 7th.—10 a.m.–1 p.m. Paper. 2 p.m.–5 p.m. Practical and Viva voce.

Treasurer's Medal and Prize in Clinical Medicine.

Monday, Sept. 10th.—10 a.m.–1 p.m. Paper. 2 p.m.–5 p.m. Commentary or topic. Date to be announced later. 10 a.m.–1 p.m. Clinical.

Treasurer's Medal and Prize in Clinical Surgery.

Tuesday, Sept. 11th.—10 a.m.–1 p.m. Paper. 2 p.m.–5 p.m. Commentary or topic. Date to be announced later. 10 a.m.–1 p.m. Clinical.

Golding Bird Medal and Prize in Obstetrics and Gynæcology.

Thursday, Sept. 13th.—10 a.m.–1p.m. Paper. 2 p.m.–3.30 p.m. Commentary or topic. Date to be announced later, Clinical and/or Viva.

Candidates for the above Examinations are required to forward their names and addresses to the Medical School Office not later than Friday, 24th August, 1945.

The Services

AWARDS.

O.B.E. (Military Division).

Lt.-Col. C. G. Baker, R.A.M.C., in recognition of gallant and distinguished services in Italy.

Lt.-Col. T. E. A. Carr, T.D., in recognition of gallant and distinguished services in Burma.

M.C.

Major C. A. G. Cook, G.M., R.A.M.C., in recognition of gallant and distinguished services in North-West Europe.

Birthday Honours

C.B.E.

Col. G. F. Charles, Army Dental Corps.

Mentioned in Dispatches.

Wing-Cmdr. P. A. Wilkinson, R.A.F. (D.).
Wing-Cmdr. O. Plowright, R.A.F.V.R.
Sqdr.-Ldr. W. L. James, R.A.F.V.R.
Sqdr.-Ldr. E. H. Jones, R.A.F.V.R.
Sqdr.-Ldr. F. L. E. Musgrove, R.A.F.V.R.
Ft.-Lt. C. H. Dhenin, G.M., R.A.F.V.R.
Sqdr.-Ldr. E. S. Venning, R.A.F.V.R.
Ft.-Lt. J. H. Flitcroft, R.A.F.V.R.

Papers by Guy's Men

Wolfe, H. R. I., and Robertson, J. M. Fatigue fracture of femur and tibia. *Lancet*, 1945, ii, 11.

Wallis, Ross. Penicillin and Osteomyelitis. *Brit. Dent. J.*, 1945, **79**, 9.

Stevens, F. N. Two cases of incomplete dichotomy. *Ibid.*, 10.

Chapman, Harold. Cases from practice. *Dental Record*, 1945, **65**, 154.

Shay, H. B. A variation of the A.P. skull X-ray. *Brit. Dent. J.*, 1945, **58**, 363.

Johnson, F. K. Sport and the Army Dental Corps. *Ibid.*, 372.

Forgacs, Paul, Rewell, R. E., and Another. Penicillin-sensitivity of hæmophilus influenzæ Two Sensitive Pathogenic Strains. *Lancet*, 1945, i, 785.

Brockington, Fraser. The fate of premature babies in Warwickshire, 1944. *Public Health*, 1945, **58**, 101.

Appointments

Mr. G. T. Mullally, M.C., M.S., F.R.C.S., has been appointed to the Civil Consulting Staff of King Edward VII's Convalescent Home for Officers at Osborne, Isle of Wight.

Change of Address

S. H. Bockner, R.A.M.C., Psychiatric Centre, 48, Mapperley Road, Nottingham.

G. W. Garland (189693), F/O., R.A.F. (V.R.) 52, High Street, Amersham, Bucks.

Mrs. K. Harvey (née Wood), 12, West Drive, Upton, Wirral, Cheshire.

T. B. Layton, D.S.O., M.S., U.N.R.R.A., Personal, c/o 618 Military Government Detachment, Belsen, B.L.A.

James W. Lee, Lieut., D.C., U.S.N.R., 31, East Cliff Street, Somerville, New Jersey, U.S.A.

Mrs. E. G. Mauleverer (née Mitton), 20, Park Lane, Salisbury.

Dr. L. Muir Smith, 5, Arlington Road, Eastbourne. (Tel.: 720.)

Miss B. Nockolds, R.N. Auxiliary Hospital, Bombay.

A. C. Price, Major, R.A.M.C., 96, British General Hospital, B.L.A.

R. H. C. Pryn, Col., R.A.M.C., 39 (Br.) General Hospital, B.L.A.

C. P. Symonds, M.A., M.D., F.R.C.P., 87, Harley Street, W.1. (Tel.: Welbeck 9020.)

H. A. Treble, B.M., B.Ch., Marden Ash 16, Ethelbert Road, Canterbury. (Tel.: 3727.)

Births

BORGHYS.—On May 24th, 1945, at the Kenwood Nursing Home, N.10, to Cynthia (née Slater), wife of Captain Paul Borghys, A.D. Corps, a sister for Diana (Helen).

FRY.—On June 10th, 1945, at Wrecclesham Grange Nursing Home, Farnham, Surrey, to Betty, wife of Ft.-Lt. J. C. Fry, R.A.F.V.R.—a brother for Hazel.

Marriages

CRABB—BUCHAN.—On June 16th, 1945, at Plymouth, H. S. Malcolm Crabb, F/O., R.A.F.V.R. (D.), to Isobel Musgrave Buchan.

DICKER—BOURNE.—On June 9th, 1945 at Meopham Parish Church, Basil H. Dicker, Surg.-Lt. (D.), R.N.V.R., to Molly Bourne.

HIND—FEARNEHOUGH.—On April 4th, 1945, at St. Paul's Cathedral, Calcutta, Alan W. Hind, Capt., R.A.M.C., to Margaret M. Fearnehough, Q.A.I.M.N.S.R.

LEE—McCALLUM.—On July 6th, 1945, at St. Stephen's Church, Sydenham Hill, London, by the Rev. Kenneth Lee (brother of the bridegroom), Ft.-Lt. H. Lincoln Lee, R.A.F.V.R., youngest son of Mr. and Mrs. H. Lee, Stockport, Cheshire, to Helen Hunter McCallum, Q.A.R.N.N.S. (R.), only daughter of Mr. and Mrs. C. H. McCallum, West Dulwich.

Deaths

KYTE.—At Guy's Hospital on July 4th, 1945, Nora Lucy Kyte, F.S.R., of the X-Ray Department.

EDS. {J.D.L.R. M.G.T.

NOVOCAIN

(Brand Ethocain Hydrochloride)
THE ORIGINAL PREPARATION
English Trade Mark No. 276477 (1905)

THE SAFEST AND MOST RELIABLE LOCAL ANÆSTHETIC
SIX TO SEVEN TIMES LESS TOXIC THAN COCAINE

Despite the war NOVOCAIN preparations are, and will continue to be, available in all forms, viz.:

Solutions in Ampoules, 1 oz. and 2 oz. Bottles Stoppered or Rubber Capped.
Tablets in various sizes; and Powder.

COCAINE-FREE LOCAL ANÆSTHETIC *Does not come under the restrictions of the Dangerous Drugs Act*

WRITE FOR LITERATURE SOLD UNDER AGREEMENT

THE SACCHARIN CORPORATION LTD. :: 84, Malford Grove, Snaresbrook, LONDON, E.18
Telegrams: "SACARINO, RUTH, LONDON." Telephone: WANSTEAD 3287

Australian Agents: J. L. BROWN & CO., 123, William Street, Melbourne, C.1

W. H. BAILEY & SON LTD.

Surgical Instruments and Appliances
Hospital and Invalid Furniture
45, Oxford Street, LONDON, W.1
GERrard 3185 and 2313

DIAGNOSTIC SETS
From £2 12s. 6d.

S/Wells Forceps, 5 inch N/P	6/-	each
SINUS Forceps, 5 inch N/P	6/-	„
5 inch N/P Dissecting Forceps	3/6	„
5 inch N/P Round-Point Scissors	5/6	„
5 inch Silver Probes	1/9	„
¼ min. Diska Clinical	2/3	„
Head Mirrors, 7 inch focal lens	13/9	„
Do. Jobson Horne pattern	19/9	„
Scalpels, with detachable blades—		
Handles	3/-	„
Blades pkt. of 6	1/6	

BAILEY'S STETHOSCOPES
(Large Selection)

Improved Binaural with stout tubing and folding spring	each	13/9—25/-
Wooden Monaural	each	8/6
Aluminium Foetal Heart	„	5/6

* *10% DISCOUNT allowed to Students* *
mentioning this advertisement.
Prices subject to alteration without notice

INEXPENSIVE DIAGNOSTIC SETS

The excellence of Hamblin's Diagnostic Sets is acknowledged by many thousands of their users. The complete set includes an electric Ophthalmoscope with a Marple mirror of stainless steel and a decentred head and large handle, an Auriscope with 3 speculæ, a Laryngoscope with laryngeal and post-nasal mirrors, and a Tongue Depressor; all to fit on the same handle, a Thudichum nasal speculum, a Double Folding Retinoscope (concave and plane mirrors) and a + 13 D condensing lens, in a velvet lined leatherette covered case, price:

£7 5s. 6d.

Alternative set with a slightly larger selection of instruments, **£7 17s. 0d.**

Ophthalmoscope only, **£3 12s. 0d.**

Smaller sets are supplied at pro rata prices, and each instrument may be had separately.

THEODORE HAMBLIN LTD
DISPENSING OPTICIANS
15 WIGMORE STREET
LONDON.W.1

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1488 *4th August, 1945* *Ninepence*

PASSIM

IN his farewell clinical lecture, entitled "Dare Quam Accipere," Mr. Layton gave us much upon which to ponder; but one of his remarks in particular still rings in the ears. It was the exclamation, "Thus are you reduced from the status of university students to that of goody-goody little schoolboys." One asked oneself what prompted Mr. Layton to say this and to lay such emphasis on the point. Had the type of student whom he saw about him changed so much, then? Was the alteration in the nature of the medical instruction that he saw meted out to them so marked? And should his remarks have been based on both these observations, which was cause and which effect? For the difference between schoolboy and student is reflected as much by the attitude of teacher to pupil as by the relation of the pupil to his work, and, indeed, it seemed to be over the former that Mr. Layton was most concerned.

In attempting to answer these questions without the assistance of Mr. Layton it is necessary, first, to assess what difference, if any, there is between the medical student of to-day and the "ideal" university student. One might gain valuable information on this topic by soliciting the opinions of one's instructors, an embarrassing process akin to shedding one's clothes in public. Moreover, when a hospital brains trust was asked a similar question a few months ago, the "brains" tactfully restricted their answers to discussions of the colour of external garments and the shape of students' beards. It might be more helpful, therefore, to remember the aphorism which describes the difference between the educations of school and university. At the first the student is made to learn; at the second he teaches himself. There is too, the intermediate stage of allowing oneself passively to be filled with knowledge. Failure to effect this transition completely results in the "goody-goody little schoolboy"—an individual who shows no signs of recovering from his early education, often a very drastic treatment in itself.

Last fortnight's "Passim," by commenting on the relative neglect of the study of patients in the wards (apart from on ward rounds) drew attention to but one symptom of what might well be a complex syndrome, a sort of dysplasia of medical education. The writer of this page chose to seat the cause of this particular symptom evenly upon a stool of responsibility, whose three legs were the student or ward intruder, the nurse or ward guardian and the difficulties of the times—this last factor underlying the first two. Some of the correspondence that this has aroused, and which we print in this edition of the *Gazette*, strives to smash the structure of that argument striking down two of its supports to leave only a single slender prop supporting an airy figment of imagination. But let us allow the letter to comment upon itself. Our correspondent writes that the most perfect example of "active harmony between students and nurses" which he has experienced was in the midwifery department of a county council hospital—bound by no ties of tradition to Guy's; and that, moreover, all those who have worked there will surely agree. If we do agree it is certain that we do not wish to. We would prefer to be able jealously to deny the right of any other hospital but Guy's to have the best harmony in its teaching wards. It would be wrong to give this matter more prominence than it has received already and we quote it only in reference to wider issues, for whether the medical student of to-day is reverting to the status of schoolboy or not, there are certainly factors more important than the above that could account for that trend. Lowering of the average age of those who enter the wards, shortages of clinical material, shorter intervals between examinations and consequently more frequent recourse to books, all these factors could have contributed. Perhaps too, the cold, baleful eye of Mr. Bevin, scrutinising us through those little buff-coloured forms that showered through the post, had its effect.

These influences were experienced by all medical schools throughout the war, but in December of 1940, coming hard upon evacuation to the sectors, Guy's College was, at a single blow, destroyed. The medical schools of the metropolitan teaching hospitals are but single cells in that vast and diffuse honeycomb, the University of London; and it is perhaps easier for their students to identify themselves as members of a hospital than of a university. Even in the more compact atmosphere of the older universities, the daughter colleges springing up, sometimes centuries later, as mere ancillary sanctuaries have later graduated into complements almost more important than the mother university. Accordingly on destruction of the College, Guy's risked conversion in the minds of her students from a place of work and leisure to a place of work; from a home to a destination at the end of a suburban journey; from a small specialised university, in fact, to a day school. It would, of course, be wrong to say that Guy's students regard the Hospital in this dreary light or that perpetual residence in Southwark within the shadow of the Hospital walls is the student's ideal existence, but restoration of our College would remind us again more strongly that we are university students and not "goody-goody little schoolboys"—if we had forgotten.

There are other more important buildings to erect, however; and it is as yet impossible to obtain a Government licence even for restoration of the College for the use of the resident medical staff; so for the present the Hostel is being used to house a number of clinical students, where, under the ward of Dr. Bishop, they represent a branch of the old College or should we call it the root of the new.

In the near future, and by kind permission of the *Sunday Times*, we will reproduce Mr. Hanslip Fletcher's drawing of Guy's, which he executed in June of this year. After this reproduction, copies may be obtained from the *Gazette* office.

Many requests have been received for copies of Dr. Bishop's article, "Guy's and the German War." These also may now be obtained from the *Gazette* office.

Fractured Ribs and Other Chest Injuries

A Clinical Lecture delivered at Guy's Hospital by R. C. BROCK, M.S., F.R.C.S.

GENTLEMEN,—Fractured ribs and other forms of injury to the chest, quite apart from gunshot wounds, have become much more common as a result of the war; this is due in part to falling masonry during aerial bombing, and in part to the greater incidence of accidents to mechanical vehicles. The former cause will be removed with the end of the war, but those injuries due to accidents to cars and lorries are likely to increase with the years.

One result of fracture of any bone is interference with the function of the part; fracture of the tibia or femur prevents the patient from walking, a troublesome but not necessarily serious result, except in the aged. The function of the bony cage of the chest is, however, intimately concerned with the two important functions of respiration and coughing, and fractures of the ribs, by interfering with these two functions, may be very serious. In the case of a fracture there is, moreover, a tendency, which has been somewhat corrected in recent years, to focus too much attention on the injury to the bone to the exclusion of the soft parts; these may, indeed, have sustained damage even more significant than the bone has suffered, although possibly not so dramatic or obvious at the time. This may be even more important in the case of chest injuries than in limb injuries for a third function of the bony chest wall is to offer protection to the contained viscera and any injury to the bony skeleton may be accompanied by severe damage to blood-vessels, lungs, heart or diaphragm.

FRACTURES OF THE BONY CAGE.

The bony thoracic cage is formed by the ribs, sternum and vertebræ, but it is important not to overlook the clavicle, scapula and humerus which often share in thoracic injuries. A fracture of the clavicle in particular is easily overlooked, and this bone should be carefully palpated in any injury in which the chest is involved. The scapula also often suffers severe comminution when the ribs are fractured by a crushing force. The spine is injured particularly by a compression force, but I shall not go

into details of thoracic spinal injuries and will only mention that if the spine is acutely flexed a fracture of the sternum may result.

The ribs may be fractured by direct or by indirect violence. The common direct njury is a kick or blow, a fall on a projecting object or a blow from hurtling masonry; often only one or two ribs are fractured unless the injury is a particularly violent one. Fracture from indirect violence occurs from compression such as from a collision between vehicles, or from falling masonry, and by a fall from a height. It is true the violence to the chest is *direct*, but the actual fracture is not truly direct, the ribs giving way according to a definite plan, depending upon the direction of the crushing force. These indirect fractures are usually multiple and, indeed, may involve almost all the ribs on one or both sides.

1. *Fractures from direct violence.*—These may be conveniently divided into four groups :—

(*a*) Solitary rib fractures.

(*b*) " Stove-in " chest, in which several ribs are fractured in two or three places and a segment of the chest-wall is loosened and forced in (Fig. 1);

(*c*) Sternal plate fracture, which typically follows a head-on collision when the sternum hits the steering-column or dash-board; a " post-mortem " plate of sternum and costal-cartilages may be stoved-in (Fig. 1).

(*d*) Compound fractures from gun-shot wounds or other penetrating objects.

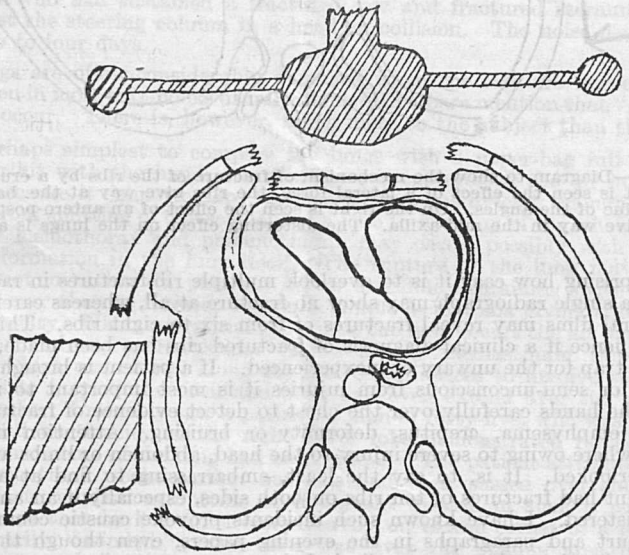


FIGURE 1.—Diagram to show the production of " stove-in " fractures of the chest. A blow from a steering column has forced in the sternum and costal cartilages, causing a " post-mortem " plate fracture. On the left a large fragment of masonry has driven in segments of ribs. The effects on the heart and lungs are also shown.

2. *Fractures from indirect violence.*—In this group the chest is crushed either by falling masonry or by a collision between vehicles, or by a fall from a height. Three types may be distinguished :—

(*a*) Antero-posterior compression; in this event the sternum is forced back towards the spine and the ribs on one *or both sides* give way roughly along the line of the mid-axilla, the ends tending to spring outwards. (Fig. 2.)

(*b*) Lateral compression; in these injuries the ribs, again on one *or both* sides, sustain a " bursting " violence and give way posteriorly, roughly in line with the angles. In this group it is common for one or both clavicles and scapulæ to be fractured; dislocation of one or both shoulder joints may also occur. (Fig. 2.)

(*c*) Oblique compression; this group is less well defined and will result in a less clear-cut type of multiple rib-fracture, although the general tendency is for fracture at or about the angles; the ribs on one side may burst along the axillary line.

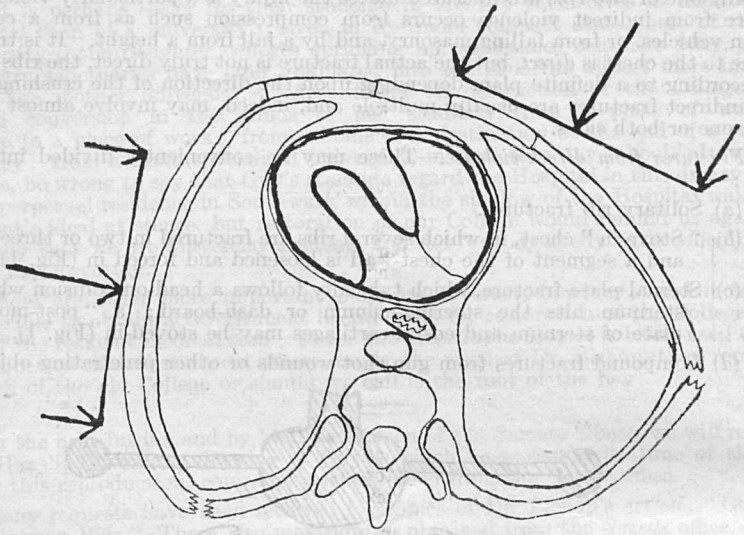


FIGURE 2.—Diagram to show the mechanism of fracture of the ribs by a crushing force. On the left is seen the effect of a lateral force, the ribs give way at the back roughly along the line of the angles. On the right is seen the effect of an antero-posterior force, the ribs give way in the mid-axilla. The distorting effect on the lungs is also shown.

It is surprising how easy it is to overlook multiple rib-fractures in radiographs of the chest; a single radiograph may show no fracture at all, whereas careful examination of several films may reveal fractures of from six to eight ribs. This may be of little consequence if a clinical diagnosis of fractured ribs has been made, but it does constitute a trap for the unwary or inexperienced. If a patient is brought to hospital unconscious or semi-unconscious from injuries it is most important to make a rule of passing the hands carefully over the chest to detect evidence of fracture as shown by surgical emphysema, crepitus, deformity or bruising. Attention may well be focused elsewhere owing to severe injury to the head, abdomen or limbs and the chest entirely overlooked. It is, to say the least, embarrassing to find at autopsy that such a patient had fractures of ten ribs on both sides, especially if an anæsthetic has been administered. I have known such incidents provoke caustic comments in the coroner's court and paragraphs in the evening papers, even though the associated injuries were by themselves necessarily lethal.

ASSOCIATED INJURIES TO SOFT PARTS AND VISCERA.

I have already mentioned that the injuries caused to the soft parts may be much more important than the actual fracture, and yet they may be completely ignored in assessing a case. In the chest wall itself are the nerves and vessels. Pain, of course, results from nerve injuries and will be considered later. Damage to the intercostal or the internal mammary vessels may lead to development of a large hæmothorax. The lungs, heart or diaphragm may be wounded by the ends of an in-driven rib; more significant is the injury that these viscera may suffer from the actual crushing force itself when the protection of the ribs is overcome. This is particularly liable to happen in children or young adults in whom the ribs are more resilient and bend a great deal before breaking. In the elderly, the ribs are more rigid and seem to take up more of the fracturing force, thus tending to spare the contained viscera.

The heart is not immune from injury, although many examples of cardiac contusion are overlooked. Dr. Hugh Barber has recorded a case in the Guy's Hospital

Reports of a man who sustained a rupture of the mitral valve, the condition being verified by autopsy twenty-five years later. I have had two cases in which I have no doubt cardiac contusion occurred. One was a man who was suffering from left-sided fibroid pulmonary tuberculosis and was running to an air-raid shelter when a bomb exploded nearby. He was hit in the back of the left chest by a large fragment of masonry and sustained a "stove-in" fracture of ribs 2–10. After a very grave illness he improved considerably, but relapsed after several weeks with attacks of paroxysmal auricular flutter which proceeded to auricular fibrillation; death followed from heart-failure. Unfortunately no autopsy was done. The other was a man who fell into the deep basement of a bombed warehouse and suffered a "stove-in" of the lower left ribs in front. His prolonged and grave shock and persistent dyspnœa and tachycardia could only be accounted for adequately by a myocardial contusion.

In this connection, also, it is important to recognise the condition which has been called "pericardial slap." After an injury auscultation over the precordium may reveal very loud noises that sound like a very gross pericardial rub plus other noisy elements that are difficult to describe or define apart from the term "slap." When heard for the first time they are striking and alarming. They are probably due to a mediastino-pericardial contusion with extravasation of blood; though they are serious in that they are usually associated with a severe injury they themselves can be ignored. I have twice been called to see patients simply because of this noise, the nature of which had not been appreciated. The last case was typical in every way, occurring in a soldier who had sustained a fractured jaw and fractured sternum from being flung against the steering column in a head-on collision. The noise usually subsides *in from two to four days.*

The lungs are often considerably damaged when the ribs are fractured, but the account given in most text-books usually stops with a bare mention that "pneumonia" is liable to occur. There is, however, much more to the subject than this.

It is perhaps simplest to compare the lungs with a paper-bag full of air which bursts when hit with the hand. As the chest is compressed the air in the lungs is entrapped because it cannot escape through a bronchus quickly enough; the injury may range from splitting of one segment of a lobe to bursting of the whole of one lung. In this way hæmothorax and pneumothorax may occur, possibly with considerable hæmatoma formation in the lung itself. The rupture of the lung may be entirely interstitial, not involving the pleura. An air and fluid containing space (like a thin-walled cyst) may then be formed, or even a simple hæmatoma giving rise to a greater or smaller opacity. When interstitial rupture of the lung occurs the air may pass along the peri-bronchial and peri-vascular planes to the mediastinum causing surgical emphysema which can extend along the intercostal spaces to involve the chest wall and upwards to involve the neck and head and even extend over the whole of the trunk and limbs. I recently saw a patient, a man of forty-five, who was coughing up blood and had an opacity in the right lower lobe demonstrated radiologically; a diagnosis of carcinoma of the lung had been made. The patient attributed his illness to a fall some three weeks earlier, but this had been passed over since so many patients seek to explain symptoms of malignant disease in such a way. Careful inquiry revealed that he had fallen very heavily on to the corner of a box and had been temporarily "winded"; the blow was over the opaque area in the lung. Bronchoscopy revealed no sign of growth and a series of radiographs showed steady diminution and final disappearance of the opacity which must have been due to a hæmatoma of the lung.

In severe crush injuries the damage to the lungs may be extreme; for instance the main bronchus may be torn across or even the whole lung found loose in the chest. I was informed of one incident in which two officers were found dead as a result of a head-on collision and their lungs were actually partly extruded through the mouth.

The diaphragm can rupture exactly like a paper-bag splits when banged with the hand, again more often in the young than in the old. This injury is associated with considerable shock and is often severe enough to prove fatal, especially if the spleen or liver is also ruptured; when the patient survives a diaphragmatic hernia is inevitable.

SECONDARY EFFECTS ON THE VISCERA.

Most of the sequelæ to these visceral injuries are well recognised and need little more than mention. They include pericardial effusion, pleural effusion, hæmothorax

with all its implications of organisation and crippling of the chest, pneumothorax and *tension pneumothorax*. Certain effects on the lung, however, require fuller description. Hæmatoma of the lung may pursue a benign course, but may lead to abscess formation or to grave pleural infection. The bruised and devitalised lung with masses of extravasated blood may slough and infection readily follows. If the original laceration involves the pleura, or if sloughing extends to the lung surface, a pyo-pneumothorax rapidly develops, often of tension type. The patient may also be in grave danger of drowning by flooding of the bronchi by the pleural exudate through the fistulous opening.

Of equal importance is *bronchial retention* and subsequent atelectasis and infection of the parenchyma. A patient with fractured ribs may find it difficult and very painful to cough; if the bronchi contain either mucus, or blood and mucus from trauma, or muco-pus from a pre-existing and aggravated bronchitis the restrained breathing and restrained coughing will cause retention of these secretions in the bronchi, air will be absorbed and atelectasis of greater or lesser degree will follow. This is particularly liable to happen in elderly and frail patients. The condition may be erroneously diagnosed as "pneumonia," and if not energetically treated so that the bronchi are emptied, a true pneumonia is liable to develop and even to proceed to lung suppuration.

One final and important sequel of the crushed chest is only too little known and must be mentioned—that is, acute dilatation of the stomach. It may occur from an injury to any part of either side of the chest and develops with alarming rapidity within a few hours. It may occur without vomiting and may be quite overlooked in a patient who is merely becoming more and more shocked and distressed and whose pulse-rate is rising rapidly. It should always be thought of in such circumstances and a stomach-tube passed if any possibility of its presence exists.

TREATMENT.

Fractured ribs present a condition which can range from the trivial to the very grave.

Simplest forms. In the simplest injuries in which there is, for instance, a crack of one or two ribs little interference is needed. The injured rib is splinted to a great extent by the adjacent ribs and often nothing more than a simple sedative or analgesic with reassurance is needed. Strapping may give considerable relief, especially if pain is severe, but it is a mistake to think that all fractured ribs require strapping. Many patients are quite comfortable without it and the strapping itself may be irksome or even painful and irritating. If the chest is at all hairy it should be shaved before strapping is applied; the strapping should extend at least three inches beyond the mid-line in front and behind. It is only rarely necessary to strap both sides. It is often worthwhile trying the effect of an injection of novocain to relieve the pain; one injection alone may give great relief, but two or three injections are usually needed.

If the condition is compound operation is, of course, needed.

"*Stove-in*" *chest.* In this condition the patient may be very gravely ill suffering from great pain and shock which will need the usual treatment. Injection of novocain is usually ineffective unless a nerve block or paravertebral injection is given away from the fractured area. Paradoxical respiration is often present, the "stove-in" area sinking in during inspiration and being pushed out during expiration; this aggravates shock and pain considerably. In addition to morphia, oxygen, and possibly transfusion, the chest must usually be strapped; if paradoxical respiration is present a pad should first be placed over the unstable area. Even with a stove-in chest it may not be necessary to apply strapping if there is no paradoxical movement and the patient can be kept reasonably comfortable without it.

Compression fracture.—In this type of injury shock is often profound, especially if the fractures are bilateral and accompanied by other injuries such as dislocated shoulders, fractured scapulæ, ruptured diaphragm, etc. Continuous oxygen, morphia to relieve pain, strapping to stabilise the chest, and transfusion may all be needed to save life. The possibility of acute gastric dilatation must be remembered.

Bronchial retention.

In both "stove-in" chest and in compression causing multiple fractures, bronchial retention must be promptly and adequately treated. The old and frail can easily fill up their bronchi and die from suffocation if proper measures are not applied. This

is particularly liable to happen during the first twelve to forty-eight hours, when the patient is so sore and so ill that there is reluctance to disturb him. He *must* be encouraged to cough and get rid of his secretions. Much can be done to help by the personal supervision of the surgeon. Morphia or other sedatives in proper doses are of great value, for if given in doses big enough to blunt the pain, but not big enough to cause drowsiness and depression of coughing and respiration, they enable the patient to cough effectively without distress. Strapping and actual support from the hand will do much to assist. Of equal importance, however, is posture; the patient should be put down on his good side with one pillow under his head but none under his shoulders or body, and urged to cough. This should be done two or three times a day and, if he can be made comfortable, he may even be left in this position for from five to fifteen minutes. More often, the patient will not tolerate the position for more than a few minutes at a time in the first few days.

When pain and weakness and abundant thick or frothy sputum make coughing ineffective, posture and assistance may fail. This is particularly likely to be the case if the ribs on both sides are fractured and even more so if the patient is a bronchitic or a heavy smoker. In such circumstances direct bronchial suction is needed, preferably by passage of a catheter through the larynx after cocainisation. This may have to be repeated three or four times a day for two or three days, but can definitely be life-saving in desperate cases.

Certain other associated conditions need brief mention.

Pneumothorax.—This may be small and can then be ignored, but if it is large, air should be aspirated; in any event a careful watch must be kept for the development of a tension pneumothorax, in which case an in-dwelling needle should be used connected to an under-water seal.

Surgical emphysema.—This is often alarming to both the patient and the doctor. In most cases it is only a nuisance and all that is needed is reassurance.

Hæmothorax.—In general this should be treated early by aspiration; all blood should be removed or else organisation of the exudate will follow with so much pleural thickening and splinting of the ribs that permanent deformity and disability may follow. In certain cases open evacuation of the blood may be needed if clotting has occurred and simple aspiration is ineffective.

Pyo-pneumothorax and empyema.—This complication may ensue and possibly with dramatic suddenness during the second week if sloughing of bruised and devitalised lung occurs. If accompanied by flooding of the lungs and tension pneumothorax prompt drainage may be needed in order to save life. In ordinary cases the pleural infection is to be treated on orthodox lines.

Injury to the diaphragm.—Ruptured diaphragm is usually accompanied by grave shock that requires appropriate treatment. In some cases early operation is needed if there is evidence of severe bleeding or rupture of the spleen. All cases, however, will need operation for repair of the diaphragm as soon as they are reasonably recovered from the other effects of the accident, in order to reduce the inevitable hernia and to prevent the onset of intestinal obstruction due to strangulation.

Physical treatment.

In all cases of fractured ribs proper attention must be given to physical treatment. This consists of breathing exercises, postural exercises and postural correction and exercises to prevent stiffness of the arm and shoulder. This physical treatment, aided by massage, can and should be started as early as possible, even within twenty-four hours of the injury. Moreover, the patient must be carefully informed of the importance of his continued and active co-operation if he is to avoid permanent disability and deformity due to fused and crowded ribs, thickened pleura, tethered diaphragm and various degrees of scoliosis. It is by no means uncommon to see a patient who has been, it is true, very ill from a severe crushed chest with hæmothorax, left with a completely immobile, flattened deformed chest with severe scoliosis, in fact a typical "chest cripple," just because no effort has been made to supply and enforce early physical treatment to prevent such a grave deformity occurring. Once the condition is established it is difficult or impossible to correct it by even the most energetic physical methods.

A Case of Multiple Swellings of Undiagnosed Origin

By C. H. KINDER, M.B., B.Ch.

THE patient, a labourer of fifty-eight years, was admitted to Addison Ward, under Mr. Slesinger, on March 11th, 1945, complaining of a swelling of the left cheek and protrusion of the right eye.

History of Present Illness.—Three months before admission the patient noticed a swelling of the left cheek which gradually became larger but produced no symptoms. About this time too, he began to salivate profusely.

Four weeks later he became aware that his right eye was protruding; this slowly became more marked, began to water and to ache slightly, but it was not till a month later (28/2/45) that he realised he was nearly blind in that eye.

At this time he was seen by his dentist on account of the swelling of his left cheek and sent to Guy's.

At the time of admission the patient felt quite well, had lost no weight, his appetite was good and his bowels regular. He had had a slight degree of frequency of micturition for some years and a loose but unproductive cough.

History of Past Diseases.—In 1931 the patient had a right inguinal hernia repaired by Mr. Davies-Colley, and at that time no swellings were apparent, nor did his right eye show proptosis. He had had bronchitis for many years and for the last seven years had been getting increasingly deaf.

Examination.—The patient was thin, but did not appear to have lost weight rapidly; his mucous membranes were not pale, and he showed a mild degree of clubbing of his fingers. Temperature: 98.2; pulse, 92; respiration, 20. Multiple swellings on the face, neck, trunk and in both groins, and a proptosis of the left eye were present.

1. *Face and Neck.*—On the left cheek there were three swellings, varying from one to three-quarters of an inch in diameter, mobile, firm, regular and of a rubbery consistency. In the line of the left parotid duct there was a hard fixed swelling a quarter of an inch in diameter.

In the right cheek there were two swellings, similar to those on the left, but one of them was fixed to the skin.

The left submandibular gland was enlarged, hard and irregular, and the right occipital and one of the lower deep cervical glands were palpable.

2. *Eyes.*—The right eye was proptosed, widening of the palpebral fissure and lid lag being present; the pupil was dilated, unreactive to light and to accommodation. Movement of the eye in a horizontal plane were absent and only slightly present in a vertical plane. The levator palpebræ superiores was not paralysed. No abnormality of the disc could be detected. The left eye was normal.

(3) *Mouth.*—In the line of the alveolar margin of the left maxilla there was a soft cystic swelling, one and a half inches long and situated on the lateral side of the alveolus. The teeth were absent in the region of the swelling, the remainder being carious.

Using bimanual palpation a swelling in the horizontal ramus of the left mandible could be felt.

4. *Back.*—There were nine swellings on the back varying in consistency, some soft, some firm and others frankly hard. Two of these were situated in the left infraspinous fossa, one adjacent to the seventh cervical spine and the rest in the lumbar region, mostly to the left of the midline. All these tumours were freely mobile on the deep structures, but attached to the skin; they were regular and smooth, and two of those situated in the lumbar region showed a slight red pigmentation. In addition, a swelling in the ninth rib situated in the right mid-axillary line was palpable. There was a regular dorsal kyphosis of the adolescent type.

Abdomen.—One inch below the left costal margin there was a swelling, half an inch in diameter, lying in the skin and red in colour. Above the right inguinal ligament was a herniotomy scar, and, on the left side, a direct, reducible inguinal hernia.

On deep palpation a firm, smooth, rounded mass could be made out, about two inches superio-medial to the left superior iliac spine. This was fixed to the posterior addominal wall and was not discernible in the loin.

The liver edge was just palpable, but the spleen could not be felt.

Both groups of superficial inguinal glands were enlarged, fixed, irregular in outline, and harder than the other swellings described. Those on the left made a swelling about three inches by one and a half inches; those on the right two inches by one inch.

No abnormality was detected on rectal examination.

Respiratory system.—Chest movements were poor and medium-sized inspiratory rales were heard over both lung fields.

No other abnormalities were found and no other glands were palpable.

Investigations.—X-ray examinations showed a cystic area in the left horizontal ramus of the mandible, the skull showed no bony abnormality and the chest a generalised increase of density in both lung fields, but no evidence of carcinoma of the bronchus. Intravenous pyelogram was normal.

The urine was normal and the Wasserman and Kahn reactions were both negative.

The blood picture, done five days prior to admission, was as follows:—Hæmoglobin, 80%; red blood count, 5.4 million; white blood count, 3,000; colour index, 0.75.

The differential cell count:—Polymorphs, 70%; eosinophils, 1%; basophils, 1%; lymphocytes, 24%; hyalines, 4%; and reticulocytes, 1%.

Dr. Waterfield reported that though there was a slight leucopenia, it was not a polynuclear leucopenia, and therefore was not suggestive of an aleukæmic leukæmia. Otherwise the blood count was normal and did not assist the diagnosis.

Five days after admission Mr. Wass took a biopsy from the right inguinal glands and removed the cutaneous swelling from below the costal margin. Dr. Gorer reported on the stained sections as follows:— "Histologically the condition is undoubtedly granulomatous, histiocytes and members of the lymphocytic series dominating the cellular reaction with a few polymorphs in certain areas. The skin nodule shows compression of the epidermis without actual invasion, while in the corion the granulomatous tissue infiltrates between the collagen bundles which appear denser than usual. The most remarkable feature is, perhaps, the invasion of arteries that is found; some of these vessels are almost completely destroyed. There is no suggestion of a follicular arrangement as is found in tubercle and Boeck's sarcoid. In some respects mycosis fungoides is suggested, but there appears to be objections to this on clinical grounds. If mycosis fungoides cannot be diagnosed, it seems best to call the condition a granulomatous arteritis."

The sections were sent to A. H. T. Robb-Smith, who agreed with Dr. Gorer's findings.

Comment.—Apart from the unusual histology of the nodules, the case is interesting and instructive from a clinical point of view. The striking points to be noted are the comparatively short history—apparently only three months, the multiplicity of tissues affected, and the different characters of the nodules; some lie in the skin, while others are deep to it; bone has been invaded and the orbit too. Lymph glands and the alveolar margin of the maxilla are also affected. Some of the swellings are soft, some firm, others hard; some are fixed, others freely mobile; some smooth, others irregular.

The diagnosis lies between the following: chronic lymphatic leukæmia, carcinomatosis, melanosis, lymphosarcoma, Hodgkins' disease, Boeck's sarcoid, and, suggested by the pathology, a granuloma, perhaps mycosis fungoides.

Leukæmia may be dismissed by the blood picture. Secondary deposits from a carcinoma or melanoma are possibilities, but no primary growth could be found and the biopsy shows a different type of histology. Both lymphosarcoma and Hodgkins' disease do not commonly occur in patients in their fifth decade; the different swellings were not uniform in consistency; and, lastly, the histology of both these conditions was unlike that found in the sections. The nodules of Boeck's sarcoid usually appear in females between the ages of fifteen and forty, and they are of a purplish colour; moreover, the histology differs.

In mycosis fungoides there is usually a long pre-mycotic stage when the patient suffers from various skin eruptions, all of which are very irritable and chronic. When the tumours appear they are soft, tomato-like, marginated, red, and have a tendency to break down and discharge foul-smelling pus. Glandular involvement is rare and leucocytosis is usual.

Thus, to sum up, it may be said that the clinical picture and the histology of the nodules taken together do not correspond with any well-defined condition and the case remains—a granuloma invading arteries.

Orpington Letter

WE have seen a fair number of performances of one kind and another on our somewhat inadequate stage since 1939, but in this week's performance of "Hay Fever" we reached the highest point of perfection so far.

The play, intrinsically difficult to act, was produced by a patient, Captain Paul Watson, with actors drawn from nurses and students, and was of the utmost excellence, both in its casting and polish. So well did all the players enter into their parts that it would be difficult to make comparisons, but if we were to do so, perhaps we would give first place to Miss Betty Scott in her interpretation of "Judith Bliss"—a part originally played by Marie Tempest, and a very difficult one at that.

We were not a little pained to read in the fifth paragraph of "Passim" (July 7th) that our patients were "in most cases no longer valuable as teaching cases and, from a therapeutic aspect, their health . . . more likely to benefit from the country air than that of the Borough."

May we again point out that we are not a convalescent home; we have by now accumulated quite a few simple stock mixtures and have even been known, on rare occasions, to operate in an emergency.

We were happy to welcome three of the Parliamentary candidates for the new division of Orpington who have spoken to the staff in the hospital, and we hope we may interpret the enthusiasm—within the widest meaning of the word—shown at their meetings as a sign that the "medicals" here are alive to their responsibilities as citizens.

The nurses have accepted the glowing tributes of the speakers with becoming modesty, and it was gratifying to hear one of them, when asked why anyone ever took up the profession "so inadequately rewarded" reply: "We don't do it for money!"

"Oh glad young Nurse, how well in you appears
The constant servin' of the antique world
When servin' sweat for duty, not for meed."

Adequate remuneration there must be, but when money and not love inspires nursing, then God grant us good health!

B. D. J.

Correspondence

Anonymous letters will not be printed in the GAZETTE *unless contributors disclose their names and addresses to the Editor.*

TIMES FOR STUDENTS IN WARDS.

To the Editor of the GAZETTE.

SIR,—Your recent editorial *re* the disharmony between nursing staff and medical students is a problem which is so small that your mention of the matter can only result in suspicion between the two parties concerned, leaving the problem little helped by your efforts.

The details of the remedy which you "make bold to suggest" I have rarely seen neglected in my two years in the wards. There have been occasions when screens were left up or beds left untidy, but these usually result in such an attack from the Sister that the victim rarely needs to be told again.

Against the nursing staff you state that many Sisters have reduced the times in which students may enter the ward. There was a tendency in this direction, but a perusal on the doors of many of the wards will reveal a generous list of the times students may enter the wards, signed by Dr. Bishop, which is effective in curtailing this practice. Several times I have been in the wards other than the times stated and, unless bed-making or meals were in progress, I have not met with any degree of coldness. Indeed, now even the most timid may enter the wards with impunity provided he can circumvent the numerous scrubbers with their dangerous pieces of soap.

In a later paragraph you mention that nurses who do not wish to abide by the principles of a teaching hospital should go elsewhere. It is interesting to observe, on this point, that the most active harmony between students and nurses I have experienced has been in the sector hospitals, and anyone who has, for example, worked in the midwifery block at Farnborough will surely agree.

In a previous *Gazette* you spoke of the gap existing between pre-clinical and clinical students. In their medical activities you will not find that gap. I would ask you,

for instance, to attend one of the Physiological Society meetings, where not only will you be repaid by a most excellent meeting, but in the spirit of cordiality existing there you will fail to observe this gap between clinical and pre-clinical students.

I feel strongly, therefore, Mr. Editor, that you should not rush into print over small matters of friction which you may think exist between two sections of the Hospital, but rather bide your time, put on your rose-coloured spectacles, and when next you look, your problem will have vanished.

Yours, etc.,

Guy's Hospital, S.E.1. G. I. TEWFIK.

HARMONY OF WORK IN GUY'S.

To the Editor of the GAZETTE.

SIR,—There are two conditions which can allow harmony of human work—one is ceaseless goodwill of all the people working; the other, a set of regulations to decide differences of opinion.

The goodwill of the nursing and medical staff at Guy's does account for much successful co-operation, but there are times when many of us feel irritable and readily leave a job to someone else or attribute a difficulty to the agency of someone else.

On these occasions when we feel irritable a set of regulations ensures that someone can be obliged to do a particular job, and prevents anyone feeling resentment that he should be blamed for what he supposed to be the omission of another.

In the course of time I have learned that there are Sisters and Registrars who adhere to a set of regulations, but the method of learning this was to do what one assumed suitable until treated as a mischievous schoolboy. Now, it is possible for a schoolboy to be mischievous only if he knows the rules of the school and it, unfornately, appears to be part of the "Guy's tradition" not to explain the laws of wards to students. For example, as a ward clerk, when I was required to estimate the percentage of hæmoglobin of a patient and found the hæmoglobinometer broken in that patients' ward, I went to fetch another of Guy's hæmoglobinometers to use for that Guy's patient. The Sister of the ward with the intact hæmoglobinometer was indignant that I should be taking a hæmoglobinometer from her ward without asking permission. The regrettable animosity between that Sister and me could have been avoided by an explanation to new ward-clerks that objects which could be moved about a ward without the Sister's permission could not be moved about a building—even temporarily —without it.

I suggest that the Guy's tradition, in the form in which it is jovially mentioned to enliven students, could be improved by some clear advice so as to avoid the students' tendency to learn by inconveniencing the nursing staff or, for that matter, the patients.

Yours faithfully,

Guy's Hospital, S.E.1 H. W. TRUSTED.

WARD HOURS FOR STUDENTS.

To the Editor of the GAZETTE.

SIR,—I desire to draw your attention to the fact that one statement in "Passim" in the last issue of the *Gazette* (July 21st, 1945) gives a wrong impression and may cause concern to old Guy's men, who always jealously guard privileges accorded to students in the Hospital. The times at which the wards are open to students are laid down quite clearly by the Governors and no change has been made in this connection for many years past. The wards of the Hospital are open to students for routine work at all times between 10 a.m. and 7 p.m., with the exception of one hour at lunch-time and three-quarters of an hour at tea-time, and no Sister has any authority to modify the times laid down. At the same time there are occasions when students are called upon to exercise a reasonable discretion, particularly at the present time when, as you point out, the war and the immediate post-war period have put so much extra work upon the Sisters and their Nurses. There is no reason why this proviso should result in any real reduction in the facilities which the students have—and indeed must have—in a teaching hospital.

I am, etc.,

T. B. JOHNSTON,

Guy's Hospital, S.E.1. Superintendent.

Sport

Cricket

GUY'S *v.* ST. BARTHOLOMEW'S.

(*Played at H.O.P. on Saturday, June 23rd.*)

Result: Lost. Score: St. Bartholomew's, 159 for eight wickets (dec.); Guy's, 145.

Guy's again won the toss and, taking the advice of the secretary, they took the field; the wicket did not, however, live up to Graham's expectations of trickiness, and runs were soon flowing freely from the opposing bats. Hawkes and Murley placed them in a good position before Hawkes was bowled by Webb for 23 with the score at 41. Of the other batsmen none seemed able to cope with the pace of Trist, who took five for 39, and wickets fell at regular intervals before Bart.'s declared at 159 for eight. Murley was still undefeated with 77, having played an attacking innings and given three unheeded chances.

The Guy's batting was true to form, so with the score three for 3, after two destructive overs by Juckes, there was no undue alarm. At this stage Evans joined Graham and, in a very short time, he hit Juckes off his length before departing with 23 useful runs to his credit. Graham, batting well, reached his half-century without a chance being given and, indomitable as ever, went on with the aid of Carton-Kelly (21) and O'Driscoll (19) to try and save the game. In attempting to score too fast he was bowled, having completed a delightful 64, and the game soon came to a close with Guy's 14 runs behind.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, I. A. H. Munro, W. B. Webb, I. L. Busbridge, W. H. Garland, W. A. Evans, G. P. Billingham, H. M. C. O'Driscoll, R. Howard Davis.

GUY'S *v.* METROPOLITAN POLICE.

(*Played at Imber Court, on Sunday, July 1st.*)

Result: Won. Score: Guy's, 193; Metropolitan Police, 53.

Guy's took a strong side down to Imber Court, and were lucky to win the toss and bat on a wicket on which an amount of rain had fallen during the night and showers continued to fall all day. The first wicket fell at 45, Murphy being bowled by Oliver for 32. At 74 Davies was caught in the slips for 12. With the score at 91 Graham joined Munro. The latter had been playing good defensive cricket but scoring very slowly. Graham more than doubled the scoring rate, his running between the wickets and his use of short runs could well be noted by all the side. Munro went on to score a solid 50 before being caught off Oliver's bowling. Graham left but shortly afterwards with the score at 160, his contribution being 44 fast-scored runs. The remaining wickets brought more useful runs in a short time—Trist, 11; Webb, 10; and Busbridge, 9 not out. The Guy's innings closed just before four o'clock with 193 runs on the board. Oliver had taken seven wickets for 65 runs.

The Police side going in to bat were far from at ease on a now more difficult wicket. Trist and Carton-Kelly, bowling extremely accurately, had four of their wickets down for 9 runs. It seemed that Guy's might return the compliment of last year when they had been dismissed for 14 runs. However, Skelton momentarily retrieved the situation before being caught off Graham for 19. Graham and Webb, replacing the primary attack, completed the dismissal and the Police side were all out for 53 runs. Trist took four wickets for 14; Carton-Kelly, three wickets for 19; Graham, two wickets for 13; and Webb, one wicket for 1.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, E. G. Murphy, D. J. Sheerboom, W. B. Webb, W. H. Garland, I. L. Busbridge, R. Howard Davies, W. A. Evans, I. A. H. Munro.

Hospital Information, etc.

Notice

ASTLEY COOPER STUDENTSHIP.
GUY'S HOSPITAL.

This studentship, tenable at Guy's Hospital Medical School, will become vacant on October 1st, 1945.

The student who is called the "Astley Cooper Assistant to the Curator of the Gordon Museum," will be elected for a period of three years.

Particulars regarding the Studentship can be obtained from the Secretary to the Astley Cooper Trustees, Medical School Office, Guy's Hospital, S.E.1, to whom applications for the post should be addressed on or before September 15th, 1945.

Pass List

CONJOINT BOARD.
FINAL EXAMINATION.

July, 1945.

Midwifery.

*D. G. Breeze	*R. D. Rogers
D. J. Dennison	C. M. Ruben
D. O'Keeffe	

Surgery.

W. W. Cree	F. W. R. Seward
E. C. Davies	H. W. Topham
*A. M. Huntley	*J. D. Wallace

Pathology.

P. K. A. Andrews	K. E. Jefferson
W. W. Cree	D. O'Keeffe
E. C. Davies	C. M. Ruben
R. V. H. Goulden	

Medicine.

*D. G. Breeze	*W. T. Harrett
*D. G. H. Davies	D. O'Keeffe
J. Fifield	J. Walsh
*G. Forrester	

* Have completed the examination.

Births

CHRISTIAN.—On July 18th, 1945, at the Middlesex Hospital, to Nancy, wife of Harold Christian—a son (James).

KELSEY.—On July 20th, 1945, at Nuffield House, S.E.1, to Maureen, wife of H. M. Kelsey, Major, R.A.M.C.—a son.

PICKARD.—On July 22nd, 1945, at Guy's Hospital, to Joan (née Packham), wife of Brian Pickard—a daughter (Diane Helen).

Marriages

BURN—BIRD.—On July 21st, 1945, at Waltham Abbey Church, Robert Richard Burn, Capt., R.A.M.C., to Margaret May Bird, S.R.N.

EDS. {J.D.L.R. M.G.T.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1489 *18th August, 1945* *Ninepence*

PASSIM

IN the year 1899 Professor Curie, working with his wife, succeeded in isolating from pitchblende the naturally occurring oxide of uranium, a substance which he called radium. The story of this event is now well established in the minds of the laity and the association of Curie with radium is as familiar to the man-in-the-street as is that of William the Conqueror with the Battle of Hastings. The significance of the discovery is, perhaps, not such common knowledge to him—significance arising from the fact that it represented the first step towards the employment of radioactive energy for the benefit of mankind.

Others following Curie have been able to demonstrate the destructive effect of this energy upon the tumour cell, with the result that an alternative to surgery in the treatment of cancer is now at our disposal, whether we use that alternative either as the method of choice or in cases where frank inoperability dictates its use.

Röntgen has demonstrated how the penetrating power of radioactive energy, in conjunction with a photographic plate, may enable us to view images of the denser structures of the body. In cases of suspected fracture a skiagram of the part concerned has become almost a routine step in the establishment of a sure diagnosis, while with the use of radio-opaque substances we can discover much regarding the state of the bronchi, kidneys, gall-bladder and alimentary canal. Mass radiography, when developed to its fullest extent, will undoubtedly be a factor of the greatest significance in checking the spread of a disease which, in this country alone, is responsible for many thousands of deaths every year.

The most recent therapeutic application of radiant energy is the intravenous administration of radioactive substances in the treatment of leukæmia. This, although at present in the experimental stage, will, if successful, surely take its place with the rest as yet another weapon in the fight against disease.

All these measures have one clear, common aim. They seek to prolong human life. Their story is one of steady development, each step a link in the chain which stretches back to Curie and to the year 1899. . . .

This year of grace 1945. Because the European War is at an end and because we are only human, we begin slowly to assume that complacent attitude of mind which is the reaction to the strain of war-time existence. We have almost forgotten the "Blitz" and the buzz-bombs, the sirens and the casualty-filled wards; Belsen seems little more than a bad dream.

Then the Atomic Bomb, final link in the chain. With almost frightening suddenness the news of its advent is brought to us in the daily Press and over the wireless. That which to most of us was hazy theory has become hard fact bringing with it, it is true, victory over Japan, but also the realisation to us of all its dreadful potentialities. This, surely, is perfection in the science of killing.

One makes no fanciful analogy in likening the present situation to that existing in an unfinished race in which Destruction has already outpaced its rival, Construction, a lead due solely to the production of the bomb which is as yet unchallenged by any rival counterpart. One does not wish to give the impression of making futile requests for a patent elixir or a cure-for-all-ills. One does, however, ask in all seriousness: "Who will win? Kill or Cure?"

The answer must lie in the attitude taken by us all the world over. In the words of Mr. Churchill: "We must indeed pray that these awful agencies will be made to conduce to peace among the nations, and that . . . they may become a perennial fountain of world prosperity."

Let us earnestly endorse these sentiments and by thought and action upon sane and rational lines, divert this power into the right channels. Only thus can the world be saved from a state of utter chaos and destruction in which no living thing could survive and in which all the hard-earned advances of medical science would be hopeless and valueless.

THIS fortnight sees a number of changes in the Staff of the Hospital. Dr. Cameron leaves his position as physician to the department for Children's Diesases to join the Consultant Staff. He and his ward rounds will be very much missed by everyone. His position is taken by Dr. Richard Ellis, whose return from the Army we welcome.

WE also welcome Dr. Symonds back to the Hospital on his return from the R.A.F. We are very sorry to lose Dr. Gerald Thomas, whose place as Medical Registrar at Guy's is taken by Dr. Forgacs.

WE are sorry to announce the resignation of Mr. John Reinhold from his position as Editor of the *Gazette*. We wish him good luck in his new appointment at Orpington. Mr. Michael Hall has been elected the new Assistant Editor.

The History and the Signs

BY HUGH BARBER,

Consulting Physician, Derbyshire Royal Infirmary, Medical Registrar, Guy's Hospital, 1903 *to* 1905.

"No machine can lie," said Father Brown; "nor can it tell the truth."—*The Mistake of the Machine* (G. K. CHESTERTON).

I. "JUST A DOCTOR WITH A STETHOSCOPE."

FORTY-FIVE years ago I heard a distinguished physician tell his clerks that, in the making of a diagnosis, one physical sign was worth pages of history. This made a great appeal to us, as you will understand; we were the proud possessors of nice new binaural stethoscopes that were going to teach us all about diseases of the heart and lungs. And furthermore, we were progressive. The physician only put one ear to a wooden instrument, which he carried in his top-hat, whereas we listened with both.

Yet through the years that have gone by there have been some sad disillusionments with regard to physical signs, but none that I can remember, in relation to case histories. What were those signs which my old friend was seeeking long ago? Did he not know that one generation is looking for a sign, which may be discredited by the next, but that clinical histories have a way of repeating themselves and live?

For a good illustration of a history that has lived we may take Heberden's description of angina pectoris, published in 1772, stressing the fact that in the early stages the symptoms come on while walking—"more especially if it be up hill and soon after eating." In modern phraseology angina of effort. Five or six generations later we are still looking for a sign, but we have faith in our diagnosis, if the history is obtained. Heberden claims to have seen a hundred patients with the history of angina pectoris. Observation of hundreds of thousands since his time, has only built upon his structure. We recognise now the submammary aching which is so common in women who are tired, and which is so different from angina. It is one of the achievements of modern cardiology to have drawn the picture of coronary thrombosis, with the characteristic signs, to explain what Heberden knew as a later manifestation of angina; but occasionally the clinical history is the main guide in this condition. Osler recounts the death of a colleague in Baltimore in 1895 in an attack of angina, describing the picture of coronary thrombosis, which in all probabilty to-day, could have been proved by the electrocardiograph; but the history is unmistakable.

It is obvious that clinical histories are sometimes unreliable; it is most unlikely that we need "pages of history"; the words were used to suggest the fullest possible. We need a short history to the point, particularly in these days of illegible handwriting. An account which we can supplement with the right questions, always remembering

that a great deal can be learned about the patient from the way in which the history is given. We must understand the English language as spoken by those of varying social status, and perhaps some day a local dialect. For concise description the Cockney has no equal.

No medical ward-clerk can work too hard at getting all the classical signs at his finger-ends. No one can claim to have studied them all until he has held a resident appointment. Individuals vary in the senses they can train, as in the degree of sense. My own personal experience has been that I made a reasonably good start in recognising the signs associated with disease; but I had to serve a long apprenticeship before I discovered that my best assistance came from searching for the physical evidences of normal viscera first with the possible variations, and then settling down to anything abnormal.

It is of interest to begin at the beginning, with Auenbrugger's *Inventum Novum* in 1761, because he percussed out the natural sound of the chest, and then described the "morbid sound," which we call dullness. He concluded that if the normal sound was not obtained, "a morbid condition of some of the parts within the chest is indicated"; and later uses the words, "that want of the natural sound." If there is an accurate history, some sputum with characteristic naked-eye appearance, and an area in which to percussion there is want of the natural sound, we have the criteria for a diagnosis. I do not underrate the importance of being able to distinguish the classical signs resulting from consolidation from those due to pleural effusion, but this may come second and the distinction is not clear on all occasions.

From Auenbrugger's own writings it seems that his new invention was really applied science which he picked up in the wine-cellar of his father's inn, where it was the custom to tap the wine-casks from above downwards, to find out how much wine remained. No doubt the "morbid sound," to his father, would be what we call resonance. His method was neglected at first—perhaps it seemed hardly dignified to treat patients as if they were wine-casks—but Napoleon Bonaparte's physician, Corvisart, revived percussion and made it more public.

Everyone knows that Laennec, in 1819, introduced mediate auscultation with his stethoscope. The story goes that he got the inspiration from the case of a fat young woman, in whom the hand could feel nothing and the direct ear was unsuitable, so he rolled up a quire of paper, through which he heard the heart quite well.

Round these two methods of percussion and auscultation what may be called an ordinary physical examination is centred. In my day, in the wards of a medical teaching school, I think the technique was excellent. Inspection and palpation were not neglected. If I have a criticism it is that sometimes there was too much subdivision of adventitious sounds, too much stress laid on variations of so-called bronchial breathing, and not enough on the importance of seeking for the evidence of normal lungs and heart. I should say with Auenbrugger, if there is a want of the natural sound to percussion, we have disease in that area. Sometimes the signs will indicate the form of disease, but frequently the history, and the associated symptoms, will settle the diagnosis. Does anyone in these days demonstrate "the cracked-pot sound"? I am inclined to think there was something in it; but I am more sure that it was safe to diagnose a cavity in the lungs, in chronic phthisis, from one's knowledge of morbid anatomy. Who was Wintrex? And what was his sign? I remember percussing the chest for a physician while he put his stethoscope inside the patient's mouth. I do not think he made much of it; perhaps Wintrex is not the right name. It is a long time ago, and in my presence he only once used the method. I do remember, however, that one of his colleagues remarked that this particular physician was still looking for a sign. What was "cog-wheel breathing"? And what about it when it was? I take a little pride in claiming that I have forgotten some signs which once I knew by name quite well. I could hear the normal sounds with a stethoscope and am glad to remember that I did not buy a phonendoscope to listen for things, which the mind could not hear.

In 1846 Addison published a paper on "The Difficulties and Fallacies in Physical diagnosis of Diseases of the Chest." I have not been able to obtain a copy; but he enumerated more than forty, from which one may conclude that much law had been laid down in the quarter of a century during which the stethoscope had been in use. Someone ought to write an essay on "The Signs of the Times," beginning with the Novum Inventum and coming to the latest machine for the diagnosis of epilepsy.

Looking back to our physical examination of the heart, when I was a registrar I think the use of the stethoscope in valvular disease was very good. This was, of course, before Mackenzie's work was published or the electrocardiograph in use. We knew little about arrhythmia. We studied the valves to the neglect of the heart muscle. We had a good deal to say about "failure of compensation." I would not suggest that there is nothing to be said about it; but that conception was rather an obsession in those days. We talked too much about "functional" bruits, which may have led students to believe they had relation to the functional capacity of the heart, whereas we ought to have labelled them bruits of no significance. Those of us who were teaching knew the mitral systolic bruit which had significance of disease. But this was the golden age of the stethoscope, which tempted the family doctor to diagnose a "weak heart" or a "strained heart" after his impressive auscultation. All the same, I think Auenbrugger's approach by searching for the normal may be applied, with benefit, to the heart sounds themselves. It would be interesting to write a paper on the heart sounds in health and disease, excluding bruits; although I admit it would make dull reading, and each one of us might have personal distinctions, from which we drew conclusions, much less definite than those we may hold in common, when there is present a characteristic diastolic bruit.

I began these notes by suggesting that my faith in the stethoscope had declined and in the history had increased. That is just the problem it is so hard to remember always. All this vexation about heart sounds, and yet Heberden has the gist of it with his words "more especially if it be up hill." That was in reference to angina effort, but it is also the gist of the functional capacity of the heart. Where are the physical signs to tell us that? In the course of our clinical work we may get the history that a man is becoming short of breath as he climbs a hill on the way home from work. That is a tip straight from the horse's mouth, although the diagnosis of heart disease can only be made by excluding other possibilities, for which radiology may be required, and by obtaining positive evidence of heart lesion, if possible, by a full investigation.

After a long apprenticeship to the study of physical signs, each one must select those of which he can make use. Osler used to quote from Froude, "the knowledge which a man can use is the only real knowledge which has life and growth in it, and converts itself into practical power." Of course, this has a much wider application than to the choice of physical signs; but I have known good family doctors who limited their knowledge of signs to those they could use wisely, which served very well for their daily round. I do not think one should begin physical examination by looking for some pathognomonic sign. It is the want of the normal somewhere which is the first step down to a diagnosis. I would not give the impression however, that an ordinary physical examination should be incomplete. I am assuming that the technique will be perfected as far as possible by each one of us, and would suggest that it is essential to give an opinion, either positive, doubtful or negative before resorting to radiology by way of confirmation.

Heberden's book was entitled *The History and Cure of Disease*. What else could he call it in his day? Sydenham, a century or so before, had used the same title and defined history as "a description that shall be at once graphic and natural." Now, at this point you may say that of course, the enchantments of a youth with just a stethoscope were sure to be followed by the disillusionments of age—when perhaps the hearing is becoming rather hard. All I wish to claim at this stage is that my old friend deceived me into thinking that, when signs were perfected, history would be less important in a diagnosis.

II. LABORATORY AND MACHINE-MADE AIDS TO DIAGNOSIS.

It was in 1900 that I visited a famous Paris Exhibition, and there in a side-show for the public, saw radiograms of tubercular disease of the lungs. I think as a profession we were a little slow. I was being taught in that year to listen for a few rales after coughing just above or below the clavicle, as the earliest signs of phthisis. One of Gee's aphorisms about phthisis, which stands in the 1908 edition, is to the effect: "Therapeutics must begin before physical signs have developed; for if you wait for physical signs, you wait too long." The use of radiology in the diagnosis of early pulmonary tuberculosis was brought before the Association of American Physicians in 1907 by Francis H. Williams. Harvey Cushing says that it aroused no discussion, and had to wait about twenty years for recognition.

This makes a good dividing line for my essay—somewhere in the nineteen-twenties —by which time most of our modern methods of physical aids to diagnosis had become well established. I wish to ask the question, as to whether these advantages have deceived us into thinking that we can rely upon some machine or special department to make a diagnosis, without reference to the history, which Sydenham said should be " at once graphic and natural " ?

Here is a simple story, told thirty-five years ago and repeating itself last year, in which the history points most of the way to a diagnosis. The patient comes under observation for pallor and prostration, which has developed in a few days, in a man previously healthy. In 1910 I was asked to take such a patient into hospital. The doctor gave me a clear history that the condition had come on comparatively suddenly. He regarded it as an unusual problem in anæmia. No doubt you have suspected the diagnosis, which proved to be a bleeding duodenal ulcer. The doctor may have missed the point of the history, and therefore failed to discover the melæna ; but he sent the history with his patient. In 1944, a soldier was admitted with similar symptoms, with similar history (when we took it ourselves), but with a note from an Army medical officer which only read : " Black stools, ? enlarged liver, ? dilated heart, ? endocarditis, ? myocarditis." The hæmoglobin reading was 40 per cent. and a rectal examination confirmed the melæna. He had collapsed at a railway station two days previously. I need not recount the progress we have made since 1910—in hæmatology, biochemistry, cardiology and radiology—but you must allow me to claim that the first approach to the case was better in 1910 than in 1944. Because, in this latter event, the patient arrives with the assumption that we shall make investigations (shall we call it the " machine-gun method of diagnosis " ?), one of which will hit the target.

Do not let me give the impression that I am reactionary—as it might be, asking for " the good old days " in which Sir Samuel Gee said phthisis must be diagnosed before there were signs or it would be too late. Nothing is further from my thoughts ; but I do wish to suggest that modern advantages in physical diagnosis make it more difficult to be a good doctor with sound knowledge of natural history.

Tweedledee said : " I generally hit everything I can see—when I get really excited." To which Tweedledum responded : " And I hit everything within reach, whether I can see it or not." If we adopt the machine-gun method of firing at everything within diagnostic reach, in an aimless way, there will be many successes, although even then a diagnosis without the history will leave us with an incomplete understanding of the patient and the problem of treatment. There are may cases, however, in which signs are wanting and investigations draw a blank. It takes a well-trained marksman to pick out the right target by direction of the history, and visible only in the light of a few symptoms. When this is successful you must not say that the physician only stood at the foot of the bed and made a shot in the dark. It can only be accomplished by one who has had long practice in choosing investigations in order of their value, as assessed in the light of the history and symptoms.

I do not like a case-sheet to be headed with a space for a " provisional diagnosis," although I admit that some label may be required in the office for admission. There used to be a little porter at Guy's called " Victor," who ran messages before the days of ward telephones, and he sometimes carried one end of a stretcher, wearing a frock coat and a bowler hat ; but he was the brains of the party. I once asked him what he was bringing to one of my beds, and he replied : " I don't know, Sir ; but I think it's a query enteric." That seems reasonable, but on the case-sheet, as the first entry, I prefer the predominant symptoms, followed by the history. Still less do I like to be told that a patient has been admitted " for investigation." It is a better compliment to the physician if the patient came in to have the benefit of his opinion. I would, however, accept admitted " for observation." If a doctor asks for an electrocardiogram the request should be granted ; but the reply should be a full report about the heart, including reference to the history. When a doctor tells his patient that he will send him to hospital " to be X-rayed to find out exactly what is the matter," it tends to give a false impression that brains and experience are not required wherewith to make a diagnosis.

The perfection of physical diagnosis is so attractive and important that there is little danger of neglect in that direction. I am thinking of the changing times. The progress is obvious, but may I say, lest we forget, that an old doctor thirty years ago would send me the essential history notes with his patient to hospital, but that many of his successors tend to assume that the physical methods available in hospital will of themselves solve the problem of diagnosis. It so happens that I wrote a chapter for

an American text-book in 1938, in which I penned the words: "Perhaps the extended use of instruments of precision has tended to lessen our interest in case histories." I was interested to find, when the book was published, that the distinguished editor had printed this sentence in italics.

Sometimes when I have talked of these ideas I have been told that all students are taught to take a careful history. I do not doubt that the majority of students do. But I find evidence, in this machine age, that the busy resident tends to neglect the history in diagnosis. A detailed history, recorded in the interests of scientific investigation of disease, may be studied at leisure, but a brief history to the point must be obtained when first seeing the patient, or one fails to get a clear conception of the problem in hand. The history is essential for interpretation of so many signs and may be a reasonable sure guide to a diagnosis when investigations and physical examination draw a blank. It will not do, however, to ignore the history until we meet a case like this because we shall not have acquired the gift of being able to assess it.

Perhaps these thoughts may be looked upon as glimpses of the obvious. But have you ever noticed that if you put something on your desk right under your nose, and pay no attention to it for a considerable period of time, you develop mind-blindness to that object, and only the upheaval of spring cleaning, which moves it to one side, will make it truly visible again? Something like this happens to the brain that does not begin by considering the history first in every case. If I tell a house-physician that I think the history usually wins, I only mean that it earns the reward which is due to that which first led to the capture of something so elusive as a correct diagnosis.

It may be that I have been prating over long about a chance remark made by a physician many years ago. The psychiatrist, however, will sympathise with my interest in case-histories, and he will underatand, that it relieves my mind to say, that the impression made upon me by this remark, while I walked the wards as an undergraduate, has been modified considerably by experience gained during the longer walk of my post-graduate studentship.

The Declining Reproduction Rate

By P. L. MASTERS, M.B., B.S.

MEASUREMENT is essential to all science. In social science it implies statistics, the collection of which is a prerequisite of the consideration of any social problem. I propose to discuss some recent statistics relating to the reproduction rate and to make some suggestions concerning their social significance.

The outstanding fact about the reproduction rate is its continued decline in all Western European countries since the end of the nineteenth century. I am purposely avoiding the use of the term "birth-rate." For, if reproduction alone is to be considered, we want to relate the number of births to the number of women of child-bearing age and not to the population as a whole as is done with the birth-rate. The latter is affected by changes in the mortality rate through their influence upon the age composition of the population. The reduction in the mortality rate in the past fifty years has, in fact, reduced the extent of the fall in the birth-rate.

Two reproduction rates are in use. The gross reproduction rate indicates the average number of girls born to a woman who lives through the child-bearing age, while the net reproduction rate shows (on the basis of present fertility and mortality) the average number of girls which will be born to a newly-born girl—*i.e.*, it allows for mortality before and during the child-bearing age. For the consideration of reproduction alone the gross reproduction rate (G.R.R.) is the best guide. R. R. Kucynski, in a paper entitled "The International Decline in Fertility," finds that for Great Britain in the period 1881–85 the G.R.R. was 2.278. Since then it has fallen continuously, apart from minor fluctuations, until in 1935 it was 0.866.

What direct causes of this marked decline must be considered? To put them in physiological sequence we may postulate—(1) later or fewer marriages; (2) increased use of contraception; (3) reduced fertility, and (4) an increase in the abortion rate. In addition, a reduction in infant mortality should be included in view of its possible influence on causes (2) and (4).

Later marriage, whatever its causes, will tend to lower the reproduction rate owing to the reduced time available for child-bearing and the decline in fertility of both sexes with age. Statistics on the matter are available ("Marriage Frequency and Economic Fluctuations in England and Wales, 1851–1934," by D. V. Glass). These show that the percentage of married women between twenty and twenty-five in 1931 was 25.81 compared with 33.46 for the year 1881—a reduction of 15 per cent. In the case of men the figures are 13.88 and 22.28—a reduction of 41 per cent. In the thirty-five to forty-five age group however, the difference is slight; 84.67 per cent. of women married in 1881 and 80.6 per cent. in 1931. The figures for men are even closer—86.22 per cent. in 1881 and 87.46 per cent. in 1931. Thus, although the proportion of people who marry at some time during the fertile period has not altered significantly, marriages are taking place later, on the average, than was the case fifty years ago. The change is too small to account for more than a small part of the big decline in the reproduction rate.

The extent of the use of birth control is impossible to estimate accurately, but the rapid increase in the demand for and the supply of knowledge concerning it in recent years makes certain a big increase in the practice of contraception since 1880.

Fertility in the restricted sense of ability to procreate cannot be assessed directly for the population as a whole owing to the use of contraception. The indirect method is open to us of considering whether there have been any changes in the factors known to be involved. There are four possible groups of factors—heredity, nutrition, infection and "function." Two generations is too short a time for significant hereditary changes to occur in the population as a whole, even if sexual selection is postulated. Nutrition has improved considerably in the past sixty years, a change more likely to improve fertility than the reverse. Infections liable to produce sterility—venereal disease, puerperal sepsis, tuberculosis—have shown a corresponding decline in the same period, and again this will tend to raise the general level of fertility. I use the word "function" to include such factors as education, work, family life, recreation and mode of living generally which, with their accompanying anxieties and responsibilities, may produce such important psychological and physiological changes in the individual. In the present connection impotence and frigidity are obvious examples of such changes, and there may be others the connection of which with reproduction is less obvious. The practice of contraception itself may be one of the changes of "function" which can lower fertility. Thus two groups of factors—nutritional and infective—have tended to raise fertility and any reduction which may have occurred must be attributed to the "functional" factors.

There are no reliable figures relating to the abortion rate for obvious reasons. The possible factors influencing the non-induced abortion rate are closely similar to those affecting fertility, and therefore the same remarks apply to likely changes in it. Induced abortion being, like contraception, a deliberate act is subject to similar influences, so that from the social point of view the two may be considered together. There should indeed be a reciprocal relationship between them in that the more widespread is the knowledge about birth-control, the less often will people need to resort to abortion.

The infant mortality rate has, of course, decreased greatly in the past fifty years. This may be a small factor in the decline in the reproduction rate in so far as it is due to deliberate choice.

Now let us sum up the evidence concerning the direct causes of the decline in the reproduction rate. Later marriage accounts for a small part only, leaving an extended use of contraception and perhaps of induced abortion to account for the rest, apart from a possible decline in fertility owing to "functional" factors. In other words, deliberate choice on the part of potential parents is the main direct factor in the decline.

Having dealt with the direct, physiological—or perhaps we should say unphysiological causes of the decline—we can now consider the indirect social factors. The influence of economic changes is illustrated by statistics compiled by D. V. Glass ("Marriage Frequency and Economic Fluctuations in England and Wales, 1851–1934). He shows that there is a close correlation between short-term fluctuations in real wages and in the marriage rate in the past eighty years. Short-term fluctuations in the reproduction rate are difficult to calculate, but may be assumed to run parallel with those of the marriage rate. Paradoxically it is commonly held that the long-term trends are opposite, real wages steadily rising as the reproduction rate has fallen. Statistics regarding changes in real wages are difficult to compile and experts disagree, but a recent study by Jürgen Kuczynski suggests that this opinion is not altogether

accurate. Kuczynski's figures show a steady rise in real wages from 59 in 1850 to 100 in 1900, apart from a short-lived drop around 1880. Since 1900 he finds a gradual fall to a minimum of 87 after World War I, followed by a gradual rise to 96 for the six years preceding World War II. If the accuracy of these figures is accepted the contrast between the correlations of long-term trends on the one hand and short-term trends on the other is not so marked after all. Nevertheless, there is a considerable discrepancy which requires explanation. I suggest that it is due to the relative nature of the standard of living. Fluctuations in wages over a short period have an obvious significance for the individual, but over long periods what affects him is not so much any change in real wages as the difference between the standard of living he has been led to expect and that which he is able to obtain. Two striking changes in Britain since 1880 have been the extension of popular education and the increase in luxury articles and entertainments available to the people as a whole. Both of these changes have so increased the range of people's wants that these are satisfied even less adequately than they were sixty years ago, in spite of the absolute increase in consumer's goods and services. In other words, there has been a general increase in what is commonly called "economic insecurity." In addition to this two factors have particularly affected the desire to have children—the increased cost of bringing up children owing to the extension of education, and the invasion of industry, commerce and the professions by women.

The social causes of the decline in the reproduction rate can now be summarised. In the first place, the increase in human needs has outstripped their supply. This is reflected in the fear on the part of parents that they will be unable to give their children the upbringing and eductation that they desire for them unless they deliberately restrict their families. In the second place, life holds many more material distractions which may outweigh the natural desire for children. And thirdly, the increase in the tempo, the anxieties and the responsibilities of life in recent years may have produced a true reduction in fertility.

Whether the decline in the reproduction rate is of importance in itself is a debatable question. It depends upon one's view of the size of population which is desirable for this country and of the change in its age composition which the decline entails. On the other hand, the undesirability of the social changes which have produced it is generally accepted and serves to emphasise the importance of the social changes which are now being planned and discussed. Public opinion has been focused primarily upon the need for a great increase in production and the provision of measures of social security such as unemployment insurance, free medical attention and family allowances, all of which will help to eliminate those social causes of the decline which may be put under the heading of want and fear. While the importance of these cannot be overestimated there are other factors of a non-economic nature which involve spiritual needs. The reactions of the people to the complexities, the rapid changes, the anxieties, the distractions and the moral uncertainties of modern life can be altered only by a re-casting of our educational aims. We must give our children a truer sense of values and of purpose in life ; a greater confidence born of knowledge, self-expression, creative activity and a faith which harmonises with modern science and controls its application. It is a difficult but vital problem. Can we achieve that measure of agreement on moral values which is needed to solve it ?

Reviews

Handbook of Physiology and Biochemistry. By J. R. S. McDowall, M.D., D.Sc., M.R.C.P. 38th edition. 1944. Published by John Murray. *Price* 25*s*.

TEXTBOOKS of physiology can be classified quantitatively as short, medium and full length, meeting roughly the needs of the L.D.S., B.D.S. and medical student respectively. This is a medium length book yet, as it is perhaps more readable than the fuller texts, may nevertheless be used by medical students if supplemented from sources of fuller information. Recent topics such as the Rh factor, siderocytes and thiouracil are mentioned in this edition and a bibliography has been added for the first time ; its last item reads : "Turner in Allen's Sex and the Internal Secretion of *Milk*." It is only fair to point out that other slips of this kind are to be found in the text.

Space does not allow of criticism of every section, but that on the thyroid calls for comment seeing that the book is written for medical students. The cardiac abnormalities of thyroid disease find no mention beyond "excessive heart rate" in hyperthyroidism. The changes in blood cholesterol and the negative calcium balance of thyrotoxicosis are omitted. Undue prominence is given to the problematical sympathetic control of the thyroid at the expense of its undoubted pituitary control. Colloid goitre is said to be prevalent "where chalk abounds as in Derbyshire." The dominant rock of that county is, of course, carboniferous limestone, while a geological error may perhaps be overlooked, the statement obscures the established fact that it is iodine content rather than the nature of local minerals that determines the incidence of colloid goitre. Finally, in the plate on thyroid histology, hypothyroidism should read "hyperthyroidism." E. V. A.

Prosthetic Dentistry. A Clinical Outline by F. W. CRADDOCK. Published by Henry Kimpton. *Price* 15*s.*

HERE at last is a neat, clean-cut presentation of the subject from a chairside point of view. We miss the lengthy chapters on topics such as the commercial preparation, properties and manipulation of plaster, and the vast tables of Brinell hardness, dimensional changes and other physical properties of denture bases. We are also spared the numerous pages which are devoted (in American text-books particularly) to those chairside techniques that, in skilful hands, with plenty of time and a stolid patient, no doubt produce the best results, but which are technically and practically beyond most students and practitioners.

Mr. Craddock confines himself to techniques which are simple and speedy, yet compatible with securing a result which is satisfactory. Nearly all his procedures are taught at Guy's, although his simplification at times seems almost heretical to the dewy-eyed student. The instance that comes to mind is his assertion that a face bow for estimating the inclination of the condylar path is a frill, and, more, an inaccurate frill which is better dispensed with. He writes: "Probably no method of recording condyle path inclination is accurate to more than plus or minus 10°." One has indeed noticed that, in the student's hands, dentures made on a fixed average articulator seem no worse than those which are made on articulators smothered in estimated variables. But the author does not advocate simplicity for its own sake if complication will secure better results, although he adds this rider: "A point is reached . . . . where the quest for further efficiency results in an elaboration and complication out of all proportion to the gain secured." Such sense is refreshing when found in a text-book written about a subject that is so often surrounded with bally-hoo.

Another chapter of this rare gem is presented in the section on "æsthetics.' Volumes have been devoted to weighty discussions on outline forms of anterior teeth as compared with full-face facial outline. Since facial outlines change, and not the teeth, and since we have seen knowledgeable men arguing over the mould type for a certain face, it seems overdone. In these days of shortage square faces have been fitted with tapering or ovoid teeth and the effect is quite pleasant. Mr. Craddock recommends square moulds for all open-faced dentures, because they expose less base to an inquiring view. He also stresses the importance of restoration of facial profile and fullness, which tend to be lost, like the wood for the trees.

With the increase expected in the standard of living, immediate dentures will be in demand, and the profession will have to meet it. We are disappointed that this branch of the subject is dealt with so briefly.

This book has been written for the laboratory student, and we recommend it for its lucidity, practicability and, above all, its sense. J. B. K.

Salts and their Reactions. By L. DOBBIN and J. MACKENZIE. Seventh edition. Pp. 246+ix. E. and S. Livingstone, Ltd. *Price* 8*s.* 6*d.*

THIS well-known text, a class-book of practical chemistry for preliminary examinations, first appeared forty years ago, and the present edition does not differ materially from its predecessor.

The introductory chapters form an excellent historical and general account of acids, bases and salts, the theoretical treatment combining simplicity and clarity. The directions next given for some forty experiments are noteworthy for the soundness of the practical advice, and are followed by chapters which deal on conventional lines with the reactions of metallic and acidic radicals (though obsolete formulæ such as HgCl for mercurous chloride might be corrected). The appended analytical schemes are not entirely satisfactory for the London 1st M.B., and the rather full section on dry-way reactions (bead tests, film deposits, etc.) appears to the reviewer to be of limited educative value.

A short chapter is devoted to some fundamental exercises in volumetric analysis; since the required precision of measurement is no more than 1 part in 400, it is a pity that some of the worked answers are given to five significant figures, for a false conception of accuracy is thereby induced. The final section, on "Some Common Organic Substances," deals with such diverse material as wood and feathers, and despite its intrinsic interest is totally inadequate as a practical course of organic chemistry. Nevertheless, any student preparing for an examination with a syllabus covered by this book will find it both reliable and informative. R. E.

Guy's Team to Belsen

J. G. Jones M. G. Davys J. V. Kilby
D. M. Strange D. G. Westbury D. H. Forsdick J. M. Mandel J. L. Turner
D. O. Davis D. M. Rahilly D. S. Hurwood J. L. Hayward

Correspondence

CLOSING OF W.V.S. CANTEEN.

To the Editor of the GAZETTE.

SIR,—During the past week the canteen run for so many years by the W.V.S., was finally closed down. Only those who have lived in the Hospital realise what a tremendous asset it was, not only for the excellent refreshments provided at a negligible cost, but as a social centre for staff, house-officers and students. I am sure that all of us Guy's men who enjoyed its amenities would like to express our thanks through your columns to the ladies who sacrificed so many of their leisure hours for the welfare of Guy's patients and staff.

I am, etc.,

Guy's Hospital, S.E.1. J. J. CONYBEARE.

SISTERS' COMMENT.

To the Editor of the GAZETTE.

SIR,—Many sisters at Guy's would like to comment on " Passim " of July 21st, 1945. That there is a rift between the nursing staff and the medical students is not true. The cause for apparent difficulties, no doubt, arises from :—

1. The condition of the wards, which at present are barely conducive to good nursing and good teaching.

2. The condition of the Hospital itself, which, with its many war-time adaptations, has had an enormous repercussion on the ward, its environment and service.

3. The inability of the Sisters to make their energies expand further. It has always been a tradition at Guy's to attempt all that one is asked to do. Small wonder, then, that the Sisters now find themselves in the unenviable position of attempting the impossible and being criticised for it.

4. The modern student himself, who has no doubt been studying under far from perfect conditions, and sometimes does not understand, and is bewildered by the necessary ward routine and the simple ward rules that his predecessors understood so well.

The second point that has been raised is the times that wards are opened and closed to students. It is not within the power of the Sisters to alter the prescribed times, so that " the coldness and displeasure of Sisters " must refer to any who infringe the authorised closing times.

The greatness of Guy's in the past was built on the fact that the patient came first. Surely few students can be so thoughtless as to stake a priority claim on ward and staff time which are at present strained to the utmost in an attempt to keep a satisfactory service for the patients. Nurses, who are also students, and themselves part of a teaching hospital, have foregone much of their studentship in the interests of serving patients (often in very menial ways).

Wards are closed, not to tantalise students, but for two reasons :—(1) For the benefit of patients (and how often women comment when men enter wards at unsuitable times); (2) so that duties for the patients may be done completely, and therefore effect good service.

The environment of a ward undoubtedly affects a patient's condition, either aggravating the cause of his illness or assisting his treatment. Real resentment of students, therefore, can only be felt if they infringe the aim of nursing, not if they annoy the nurses by adding to their duties.

The Ward Sisters are fully aware of the important part that Guy's has to play in the training of doctors; therefore this letter may perhaps assist in a better understanding and greater co-operation during this difficult period of our history.

We are, etc.,

SOME OF THE SISTERS.

Guy's Hospital, S.E.1.

Sport

Cricket

GUY'S *v.* ORPINGTON C.C.

(*Played at H.O.P. on Saturday, July 7th.*)

Result: Won. Score: Guy's, 139; Orpington C.C., 115.

Fielding a somewhat weakened side, Guy's won the toss and batted. Davis was dismissed for 8 with the score at 15. Sheerboom, in a matter of minutes, collected 14 before being caught off a mis-drive. Graham joined Williams, who was batting very well indeed. The score was taken to 78 before Graham (15) was given out l.b.w. Williams continued to bat soundly and was unlucky to be bowled for 47. Holmes (24) and Billingham (18) were the only other two to reach double figures. Holmes batted immaculately if a trifle slowly, and his contribution was most useful. Guy's were finally dismissed for 139.

Orpington opened confidently against the somewhat erratic bowling of Trist and Parsons. The first wicket fell at 32 to Trist, and Webb, in his first over, took another wicket. However, runs mounted and wickets fell but slowly. At the fall of the fifth wicket Orpington had 87, but with the loss of that wicket Pearce also left, having scored 51 of the runs. The bowling was shared mainly by Trist, Webb and Evans—the latter bowling very steadily indeed. Repeated changes of these three bowlers took the wickets. The ninth wicket fell to a superb catch of Evans. The last man was bowled by Webb the next ball, and Orpington were dismissed with ten minutes to spare still 24 runs behind. Webb had taken five wickets for 29 and Trist four wickets for 34.

Team.—E. W. Graham, A. E. Trist, D. J. Sheerboom, W. B. Webb, J. D. Williams, W. A. Evans, R. Howard Davis, G. P. Billingham, I. L. Busbridge, J. B. Parsons, P. S. Holmes.

GUY'S *v.* HONOR OAK C.C.

(*Played at Dulwich Common on Saturday, July 21st,*)

Result: Lost. Scores: Honor Oak C.C., 207 for six wickets (declared); Guy's, 86.

Guy's lost the toss and the home side chose to bat. The Hospital's bowling, in the absence of Trist, was opened by Garland and Carton-Kelly. Honor Oak seemed little deterred by these bowlers and scored steadily. In the first hour they had amassed 69 for three wickets. The rate of scoring in the next hour increased rapidly, and by five o'clock the side was able to declare with 207 for six wickets. Evans had taken three wickets for 37 runs; Webb and Carton-Kelly both bowled well and were unlucky to be credited with but one wicket apiece.

Guy's batting opened disastrously, three wickets falling for 14 runs. Garland, however, treating the bowling with anything but respect, scored 26 before mishitting a straight drive and being caught and bowled. Wickets just continued to fall and, except for a bright bout of hitting by Pritchard and Foster, the Guy's batsmen left in a steady procession. The total finally reached was 86.

Team.—L. D. Carton-Kelly, E. W. Graham, W. B. Webb, J. D. Williams, I. A. H. Munro, W. H. Garland, W. A. Evans, K. G. B. Pritchard, F. R. Lambert, R. Harvard Davis, K. Foster.

GUY'S *v.* BUCCANEERS C.C.

(*Played at H.O.P. on Sunday, July 22nd.*)

Result: Lost. Scores: Guy's, 126; Buccaneers C.C., 127 for six wickets.

Against a strong side fielded by the Buccaneers Guy's went in to bat. Runs came slowly and regularly, most of the side contributing, but only Evans reached and passed 20. He batted well for his 26; was perhaps a little unlucky to be very well caught by Davies, of Kent, fielding at deep mid-wicket. Young, the Cambridge Blue—but recently returned from a German P.O.W. camp — bowled his leg breaks to good purpose, taking five wickets for 24 runs. Guy's left the wicket having scored 126, extras generously presenting them with 27 runs.

The Buccaneers were never at home to the bowling of Carton-Kelly, and it was his accuracy of length and excellence of the one that "goes away" that nearly turned the game in the Hospital's favour. The first three wickets all fell in a similar manner. The ball hit by the batsmen was deflected by wicket-keeper, Pritchard, and caught at first slip by Trist. Trist took three beautiful one-handed catches, making them all look ridiculously easy. With J. W. Davies gone and three wickets down for 40, Guy's were making their opponents fight hard for runs. However, Shirreff then came in and scored a fine 56, which left the issue in no doubt. Before the Buccaneers had reached the Guy's total another three wickets fell to Carton-Kelly's "out-swinger." The captain bowled well indeed to take six for 39.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, J. D. Williams, W. B. Webb, I. A. H. Munro, W. A. Evans, K. G. B. Pritchard, R. Harvard Davis, G. P. Billington, F. R. Lambert.

GUY'S *v.* ST. MARY'S HOSPITAL.

(*Played at Teddington on Saturday, July 28th.*)

Result: Drawn. Scores: St. Mary's Hospital, 164 for nine (declared); Guy's 120 for five wickets.

Guy's took a strong side down to Teddington to play a similarly powerful Mary's XI. Mary's, winning the toss, decided to bat. Trist and Carton-Kelly got very little out of the wicket, and it was not until Webb came on to bowl that it was seen that the wicket was taking spin. Webb bowled excellently, but the Mary's batsmen scored at a fast rate. Bennett, their captain, played a grand innings of 60. Wilkinson and Watson both added 20's. Webb and Graham attacked the batsmen continually with their flighted deliveries spinning fast off the wicket, Webb taking six for 46. Mary's were able to declare at five o'clock with nine wickets lost for 164 runs, leaving Guy's two hours to get the runs.

Guy's opened slowly, losing Williams with the score at 4. Murphy and Harvard Davis carried the total run by run to 96 against the very accurate bowling and exceptionally keen ground fielding of the Mary's side. Davis left at 7.15 p.m. and the last fifteen minutes were spent in collecting 30 runs and losing four wickets. Harvard Davis had scored 34 very fine runs and Murphy 48 in his usual immaculate style, a second wicket partnership of 92 runs. When stumps were drawn Guy's had 120 runs for the loss of five wickets.

Team.—L. D. Carton-Kelly, E. W. Graham, E. G. Murphy, A. E. Trist, R. G. L. Brittain, J. D. Williams, W. B. Webb, W. H. Garland, W. A. Evans, I. A. H. Munro, R. Harvard Davis.

Hospital Information, etc.

Notice

ASTLEY COOPER STUDENTSHIP.
GUY'S HOSPITAL.

This studentship, tenable at Guy's Hospital Medical School, will become vacant on October 1st, 1945.

The student who is called the "Astley Cooper Assistant to the Curator of the Gordon Museum," will be elected for a period of three years.

Particulars regarding the Studentship can be obtained from the Secretary to the Astley Cooper Trustees, Medical School Office, Guy's Hospital, S.E.1, to whom applications for the post should be addressed on or before September 15th, 1945.

Papers by Guy's Men

Erskine, David. Difficulties in the successful treatment of the Venereal Disease patient. *Brit. J. Ven. Dis.*, 1945, **21**, 47.

Knott, F. A. Transfusion fatalities. *Clin. J.*, 1945, **74**, 144.

Bulleid, Arthur. The ætiology and treatment of gingivitis. *Med. Pr. & Circ.*, 1945, **114**, 38.

Douglas, Donald M. Irreparable vesico-vaginal fistula in Iraq. *Brit. Med. J.*, 1945, ii, 78.

Ellis, R. W. B. Child life and health in Belgium during and after the German occupation. (Abstract.) *Proc. Roy. Soc., Med.*, 1945, **38**, 449.

Stebbing, G. F. Diagnosis of cancer in a National Medical Service. *Lancet*, 1945, ii, 65.

Gray, John. Modern Views on calculus formation. *Med. Pr. & Circ.*, 1945, 24, 59.

Change of Address

A. Lincoln Bell, Lieut., R.A.M.C., c/o Grindlay & Co., Bombay.

Frank Cook F.R.C.S., 31, Cumberland Mansions, Bryanston Square, W.1 (Phone: Ambassador 2505) (private); 12, Upper Wimpole Street, W.1 ('Phone: Welbeck 1052) (professional unchanged).

C. S. Darke, Major, R.A.M.C., No. 3 (E.H.) General Hospital, P.O. Nyeri Station, Kenya.

A. E. Grace, L.D.S., R.C.S., 34, Kingnorth Gardens, Folkestone.

J. O. Laws (306338), Capt., R.A.M.C., Central Military Pathology Laboratory, Poona, India.

T. L. T. Lewis, Capt., S.A.M.C., att. R.A.M.C., 72 (Br.) General Hospital, C.M.F.

W. B. D. Maile, S/Ldr., R.A.F., 31 Anti-Malaria Control, S.E.A.A. Force.

H. C. Muirhead, Major, R.A.M.C., 108 British General Hospital, B.L.A.

J. Tudor, Lieut., R.A.M.C. (342516), 52nd W.A. General Hospital, Gold Coast, W.A.C.

The Services

AWARDS.

Mentioned in Dispatches.

Surg.-Lieut.-Cmdr. (D.) A. G. K. Heberlein, R.N., for gallant and distinguished services in the Middle East.

Appointment

Mr. R. Davies-Colley has been elected Erasmus Wilson demonstrator for 1946.

Births

CHRISTIAN.—On July 18th, 1945, at the Middlesex Hospital, to Nancy, wife of Harold Christian, of Rosslyn Park, Hampstead—a son (James).

GOODRIDGE.—On May 31st, 1945, at Tonbridge, to Joan (née Beazley), wife of Derek Goodridge, Surg.-Lieut.-Cdr. (D.), R.N.—a daughter (Susan Lesley).

JONES.—On July 22nd, 1945, at Astoria Nursing Home, Colwyn Bay, to Win (née Barber), wife of J. Emrys Jones, Gowerdale, Lloyd Street, Llandudno—a son.

KILPATRICK.—On August 2, 1945, at Nuffield House, Guy's Hospital, to Eileadh (née Morton), wife of F. R. Kilpatrick, M.S., —a son (Stewart Matheson).

WHEELER.—On July 30th, 1945, at Sunnymede, Forder Valley Road, Marsh Mills, Plymouth, to Laurie, wife of Surg.-Cdmr. S. J. Wheeler, R.N.—a son.

Marriages

DICKER—BOURNE.—On June 9th, 1945, at the Church of St. John the Baptist, Meopham, B. H. Dicker, Surg.-Lt. (D), R.N.V.R., only son of Mr. and Mrs. C. S. Dicker of Sutton, Surrey, to J olly, only daughter of Mr. and Mrs. H. J. Bourne, of Meopham, Kent.

EVANS—BROUGHTON.—On June 26th, 1945, at Marylebone, G. M. Evans, Capt., R.A.M.C., to Hazel Broughton, S.R.N.

HANKEY—COULSON.—On July 7th, 1945, at Reigate, George Trevor Hankey, Lt.-Col., R.A.M.C., to Mary Isobel Coulson.

HARVEY—WOOD.—At Woodchurch, on June 14th, 1945, F/O. P. D. Harvey, R.A.F.V.R., to Kathleen Wood, S.R.N., younger daughter of Mr. and Mrs. Norman Wood, Upton, Wirral.

LEASK—ROBERTS.—On July 4th, 1945, in Rome, A. R. Leask, Major, R.A.M.C., to Deira Roberts.

Deaths

JONES.—On August 3rd, 1945, at Alton, after a short illness, Charles Edward Mellersh Jones, B.A., M.B., B.Ch. (Cantab), Medical Superintendent Lord Mayor Treloar Hospital.

MACRAE-GIBSON.—On August —, 1945, the result of an accident abroad, Angus Charles Macrae-Gibson, M.B., B.S., Surg.-Lieut., R.N.V.R.

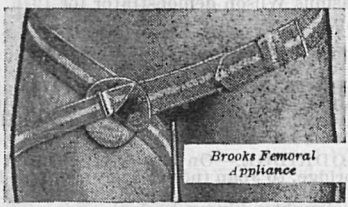
STRICK.—On Thursday, August 9th, 1945, at Guy's Hospital, Helen H. Strick, Lady Pupil and Sister, Guy's Hospital, 1885–1905; Lady Superintendent, Guy's Trained Nurses' Institute to June, 1913, aged eighty five years.

EDS. {M.G.T. J.M.H.

BROOKS Rupture Appliances

★ for every known type of

HERNIA



Brooks Femoral Appliance

Every Brooks Appliance is carefully made to individual measurements, and is guaranteed to fit perfectly and to hold securely. In addition to the usual types (inguinal, scrotal, umbilical, femoral, etc.), we also make tropical Rupture Appliances, Bathing and Swim Trusses, Children's and Babies' Appliances and also Belts of all kinds. In fact, our range includes everything for the ruptured, and we are privileged to co-operate with an increasing number of medical men and hospitals.

When writing for details please enclose 2d. Stamp to conform with Government regulations.

★ *Patented in England and thirteen foreign countries. Sold the World over*

BROOKS Appliance Co., Ltd.,

(301K) 80, Chancery Lane, London, W.C.2

Also at Buenos Aires, Johannesburg, Sydney, Melbourne, Calcutta, Durban, etc

Germolene

ANTISEPTIC OINTMENT

MEDICALLY APPROVED ASEPTIC DRESSING

Awarded 4 Gold Medals

THE following extract from a report by a Harley Street doctor regarding the healing powers of Germolene Ointment will interest other members of the medical profession and nurses too.

"Germolene Ointment combines a strong germicidal action with very effective detergent and soothing properties. It is a most excellent application for skin affections—and the best remedy I have ever found for insect bites and stings . . . a very valuable preparation for doctors' use."

Germolene reduces inflammation, suppresses septic conditions and rapidly heals open wounds.

To members of the Medical Profession and to Nurses who enclose their professional Card a generous trial supply of Germolene will gladly be sent gratis on application to:

VENO DRUG Co., Ltd.

420 CHESTER ROAD, MANCHESTER, 16

1/4 & 3/3 per tin (inc. purchase tax)

INEXPENSIVE DIAGNOSTIC SETS

The excellence of Hamblin's Diagnostic Sets is acknowledged by many thousands of their users. The complete set includes an electric Ophthalmoscope with a Marple mirror of stainless steel and a decentred head and large handle, an Auriscope with 3 speculæ, a Laryngoscope with laryngeal and post-nasal mirrors, and a Tongue Depressor; all to fit on the same handle, a Thudichum nasal speculum, a Double Folding Retinoscope (concave and plane mirrors) and a + 13 D condensing lens, in a velvet lined leatherette covered case, price:

£7 5s. 6d.

Alternative set with a slightly larger selection of instruments, **£7 17s. 0d.**

Ophthalmoscope only, **£3 12s. 0d.**

Smaller sets are supplied at pro rata prices, and each instrument may be had separately.

THEODORE HAMBLIN LTD
DISPENSING OPTICIANS
15 WIGMORE STREET
LONDON W.1

VALUABLE BOOK FREE

ARE YOU PREPARING FOR ANY MEDICAL, SURGICAL, or DENTAL EXAMINATION?

Send Coupon below for our valuable publication

"Guide to Medical Examinations"

Principal Contents:

The Examinations of the Conjoint Board.
The M.B. and M.D. Degrees of all British Universities.
How to pass the F.R.C.S. Exam.
The M.S. Lond. and other Higher Surgical Examinations.
The M.R.C.P. London.
The D.P.H. and how to obtain it.
The Diploma in Anæsthetics.
The Diploma in Psychological Medicine.
The Diploma in Ophthalmology.
The Diploma in Laryngology.
Diploma in Radiology.
The D.R.C.O.G. and M.R.C.O.G.
The Diploma in Child Health.

Do not fail to get a copy of this Book before commencing preparation for any Examination. It contains a large amount of valuable information. Dental Examinations in special dental guide.

SEND FOR YOUR COPY NOW!

The Secretary,
MEDICAL CORRESPONDENCE COLLEGE,
19 Welbeck Street, Cavendish Square, London, W.1

Sir,—*Please send me a copy of your "Guide to Medical Examinations" by return.*

Name .....

Address .....

Examination in which interested .....

G.H.G.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1490 *1st September, 1945* *Ninepence*

PASSIM

ABOUT a hundred medical students enter this Hospital annually. For what reasons do they choose Guy's rather than any other hospital? Some follow automatically in their fathers' footsteps: others have heard of the Guy's tradition. Some are rugger players: others have blindfolded themselves and set about the problem with a pin. But a good majority settling themselves fairly and squarely to scrutinise the information they glean from prospectuses and from their friends, judge therefrom, and the rough measure-stick which they often use is the number of teaching beds available at a particular hospital in proportion to the number of students to be taught there. Now, while there is no immediate likelihood of any of the London medical schools becoming numerically deficient in entrants, the widest choice of the best students will be the prerogative of the hospital whose reputation—be it founded only on such rough-and-ready standards as we have mentioned—is at present ascendant; for contemporary domestic history demonstrates what short shrift past traditions receive at the hands of present realities. We have called the relative quantity of teaching material, but a rough measure of a hospital's teaching efficiency; but when the quality of teachers is as consistently high as it probably is throughout the London schools—it is not at all a bad standard. Of all the London teaching hospitals few have undergone such war-time mutilations in both bed capacity and teaching staff as Guy's, but although this may be widely appreciated, the reputation of this Hospital in the imminent future will rest, not so much on a difference between her war-time and post-war conditions, however favourable the change may be; as on a comparison both with her pre-war state and with the contemporary condition of the other teaching hospitals. Therefore, even as we have suffered more, so must our cure be more promptly started even though that cure must itself be an improvisation until the new Guy's is built.

The shortage of teaching staff is being relieved with commendable speed as numbers of the staff make welcome reappearances from the Forces. But this relief demonstrates only more vividly the present embarrassing lack of clinical material; for while the queues and bedside stampedes which are now ward rounds may be alleviated, the actual sum of clinical symptoms and signs that are to be found will be unaltered. It may be argued that the shortage will be made good by the re-opening of certain wards in the Surgical block; bearing in mind our unpredictable future in the base hospitals however and the length of time we waited before Lydia and Queen alone neared completion, the need for a more certain and more rapidly improvised plan is evident. One that has been suggested, and that would provide an immediate increase in the number of general medical and surgical teaching beds is the evacuation from the Hospital of all the special departments, leaving behind only a few emergency beds and the Out-patient's departments. This would complete a scheme that has been partially carried into effect throughout the war, when the orthopædic and much of the gynæcological and ear, nose and throat departments moved down to Orpington and the deep X-ray unit went to The Wildernesse. As things stand at Guy's at present, these beds represent an inadequacy of teaching material in special subjects, at the price of a useful sum total of general teaching space. The destination to which these departments could be sent presents a problem which could be solved by our being allowed to retain one of our base hospitals, which might then remain as a centre for the teaching of the specialties.

As with all improvisations such a scheme would have disadvantages. The undesirable and unnatural segregation of the specialties from the field of general medicine and surgery might be cited; and the question of whether the number of beds released repaid the troubles of the removals could be asked. But an alternative is not easy to find. An increase in the number of ward rounds conducted and attended in surrounding hospitals is a practice fallen into partial disuse, the revival of which would be most beneficial on general and special teaching alike. But it would not afford

the student the same opportunities for clerking patients as he would have if the cases were in our own wards.

Nevertheless, whatever scheme is adopted to tide over this difficult time and to build up for Guy's students peace-time opportunities out of war-time difficulties, it is certain that it must soon be put into operation. To live on our tradition would be to diminish it.

WE have been asked to publish the sums raised by The Wildernesse Garden Party, held on June 20th, 1945, in aid of the Sir Cosmo and Lady Bonsor Memorial Scholarship and the Hospital Rebuilding Fund; and by the Guy's Nurses' Fete, held on August 15th, 1945, in Orpington Hospital's grounds, and by kind permission of the Kent County Council, in aid of Guy's Rebuilding Fund. They are £900 and £800 respectively.

READERS are again reminded that copies of Mr. Hanslip Fletcher's print published in this edition of the *Gazette* and of Dr. Bishop's article, "Guy's and the German War," now complete with map, may be obtained in the *Gazette* office. The four pages of pictures, published in the centre of this *Gazette*, are presented as a pictorial résumé of Guy's from 1939 to 1945.

Obituary

ANGUS CHARLES MACRAE-GIBSON.

ANGUS MACRAE-GIBSON'S death early in August following a rugger accident in India came as a great shock to his friends at Guy's. In October, 1938, Angus entered Guy's from St. Dunstan's College, Catford, and qualified M.B., B.S., London, in April, 1943. He was always a hardworking student and a delightful colleague, and subsequently was Out-patient officer at Guy's and House Surgeon at The Wildernesse. In 1944 he joined the R.N.V.R.

During the war years Angus was one of the stalwarts of the first XV and played in the centenary match, 1943. He will be remembered as a most keen and loyal member of his side. His position was usually that of wing three-quarter; although not very fast, he was a most determined runner and his tackling was excellent.

To his brother Neil, who often played with him, and his mother and father, who have so regularly watched the Hospital matches, we extend our sympathy in this their untimely loss.

F. R. K.

British Dental Students Association

ANNUAL GENERAL MEETING.

THE annual general meeting for 1945 was held at Newcastle Dental School on Wednesday, July 25th, 1945, under the chairmanship of Professor R. V. Bradlaw. Delegates representing the students of the dental schools of England and Scotland were present.

Before the meeting an official luncheon was held, where we were honoured to have present Professor Bradlaw, the retiring President; Professor Roberts, of Sheffield Dental School the Vice-Chancellor of Durham University, and Surgeon Rear-Admiral Fletcher, Director of the Royal Naval Dental Service.

After the presidential address reports from the North, Midland and Southern Regions were read and the proposal for affiliation to the British Dental Association approved by the delegates.

We were then pleased to welcome Professor Roberts as the President of the Association for 1945–46. Student officers for the year were then elected and various other matters discussed.

On the previous two days the delegates attended the jubilee celebrations of the Newcastle Dental School, consisting of a clinical meeting; an address by Mrs. Lilian Lindsay on "The History of Dentistry"; the conferment of the Honorary Degree of Master of Dental Surgery on Admiral Fletcher at Durham Castle; and various social gatherings.

Full details of all matters discussed at the annual general meeting will be given at the next meeting of the Dental Society.

P. B. SMITH, G. R. M. MOTE,
Guy's B.D.S.A. Representatives.

Pains in the Legs in Children

A Clinical Lecture delivered at Guy's Hospital by H. C. CAMERON, M.D., F.R.C.P.

GENTLEMEN,—It is a good plan in practice among children to have your knowledge, acquired by reading, cross-indexed in your mind, as it were, under the headings of the presenting symptom—that is, under the complaint which the mother tenders to you, the thing that is worrying her about the child. You will find, I think, in dealing with children even more than with adults, that certain complaints, described in case after case in almost identical words, keep on presenting themselves. The child is brought to you, for example, for abdominal pain or for abdominal swelling, for refusal to take food or for vomiting, for fever of obscure origin, for inability to walk or to talk, and so forth.

I take as an example the complaint of pain in the legs. In dealing with children you must usually divide this index in your mind into two parts—the complaint as it occurs in infancy and the complaint as it occurs in the older child.

In infants there are perhaps four conditions which you must pass in review when you are confronted with the complaint that the baby cries whenever the leg is touched or moved and that it will not use it.

1. Syphilitic osteochondritis or periostitis (the so-called syphilitic epiphysitis.
2. Infantile scurvy.
3. Infantile osteomyelitis or suppurative arthritis.
4. Pneumococcal arthritis.

Let us consider each in turn :—

Syphilitic osteochondritis is a manifestation of secondary syphilis in the congenital form of the disease. It is not, as a rule, the earliest manifestation of the disease, so that, usually, other symptoms such as snuffles, rash or enlargement of lymphatic glands will be present at the same time. It may make its appearance as early as the sixth week of life. After the sixth month we do not meet it. These age-limits are important because they alone serve to distinguish syphilitic changes from the changes of infantile scurvy, which does not occur until after the sixth month of life.

An infant always tends to throw a painful limb completely out of action and keep it immobile. So striking is this tendency that both in syphilis and in scurvy the complaint is sometimes of paralysis of the limb and the description pseudo paresis is commonly applied to both conditions. As you approach and begin to make some examination the infant will almost certainly begin to cry, either because you have provoked pain by moving the limb or because the child fears that you will do so. A baby, of course, does not cry and remain immobile. The whole body is thrown into restless movement and this movement involves both arms and legs. But this particular baby as it cries will, as it were, leave the painful leg out of its movements. While the other limbs take part in the emotional display, the affected limb will stay motionless. On palpation you will almost certainly detect a considerable thickening of the lower end of the shaft of the femur or less commonly of the upper end of the tibia. I show you an X-ray of such a case. X-ray examination will always make the diagnosis clear, although the changes in this particular case are unusually marked. Note especially the thickening of the bone laid down by the stimulated periosteum, which gives a sort of double outline to the shaft of the long bone. The degree of pain and swelling shown clinically does not at all correspond to the extent of the changes in the bone shown by X-ray examination. It is quite common to find changes at the ends of long bones which have shown no clinical symptoms at all and in all four limbs when one alone has been painful, swollen and motionless. It follows that in a doubtful case of syphilis, when, perhaps, the Wassermann test has been doubtful or inconstant, an X-ray examination may serve to establish the diagnosis beyond doubt. Anti-syphilitic treatment produces a rapid cessation of pain and a more gradual diminution of the swelling.

Infantile Scurvy.—As with syphilis the pseudoparesis and swelling of the limb in scurvy is not likely to be the only symptom. As a rule the age—seven months to fourteen months—is such that the incisor teeth are recently erupted and, if so, the little tooth will be found projecting from an encroachment of reddened spongy gum. Other evidence of scurvy, purpuric spots or orbital hæmorrhage or hæmaturia may also be present. Because the baby with scurvy is always much older than the baby with

syphilitic osteochondritis, his reaction to the pain is more developed and more significant. As a rule, the mother will begin by telling you that whereas the baby formerly loved his bath and lay kicking in it and laughing, he now screams with fear at the sight of it. She will tell you that whereas formerly her baby greeted her with delight, holding out his arms to be picked up, he now seems to have developed a fear of her and screams at her approach.

The swelling at the lower end of the femur at first may not be very obvious or easy to palpate. A thin layer of blood has been exuded between the periosteum and the bone. It is only in late and neglected cases that this hæmorrhagic layer becomes ossified and a considerable tumour forms. Before infantile scurvy was recognised and occasionally even to-day, such cases are apt to be confounded with sarcoma; a bad mistake if it leads to amputation. The X-ray of scorbutic pseudoparesis in the early stages, for the same reason, does not show so obvious a picture as that of syphilitic periostitis. I show you an X-ray of a later case where ossification is far advanced. In the earlier stages the most obvious abnormality is the dense transverse line which separates epiphysis from diaphysis. This is due to an intense deposit of calcium in what is called the lattice. The lattice is the framework of calcified matrix, which precedes ossification and which normally is replaced almost as soon as it is formed. In scurvy it is of great depth. It is intensely brittle, almost like china, and is easily fractured, so that separation of the epiphysis at this point easily occurs. The bone in the neighbourhood is much rarified and shows a faint shadow. One point, which results from all this, is perhaps worth mentioning in these days when the public conscience with regard to the treatment of children is so much aroused. The frightened screams of the child and its apparent fear of the mother or foster-mother may lead to charges of cruelty. In one case which came under my notice the body was covered by bruises and the police-surgeon had discovered a "fracture of the femur." Had the true nature of the case not been recognised it might have gone hard with the mother.

Nowadays, with the stress laid upon the need for a daily intake of fruit juice, the disease is rare. Formerly it was common at least among the infants of the well-to-do, reared by hand upon some proprietary food with all rigidity. The baby of the poor, more apt to get a lick of anything that was going, was less commonly affected.

If you have to treat a case you will find that the pain and swelling rapidly disappears if orange-juice or ascorbic acid is given freely. Until recovery, handling must be reduced to a minimum. The most gentle movement may result in fracture.

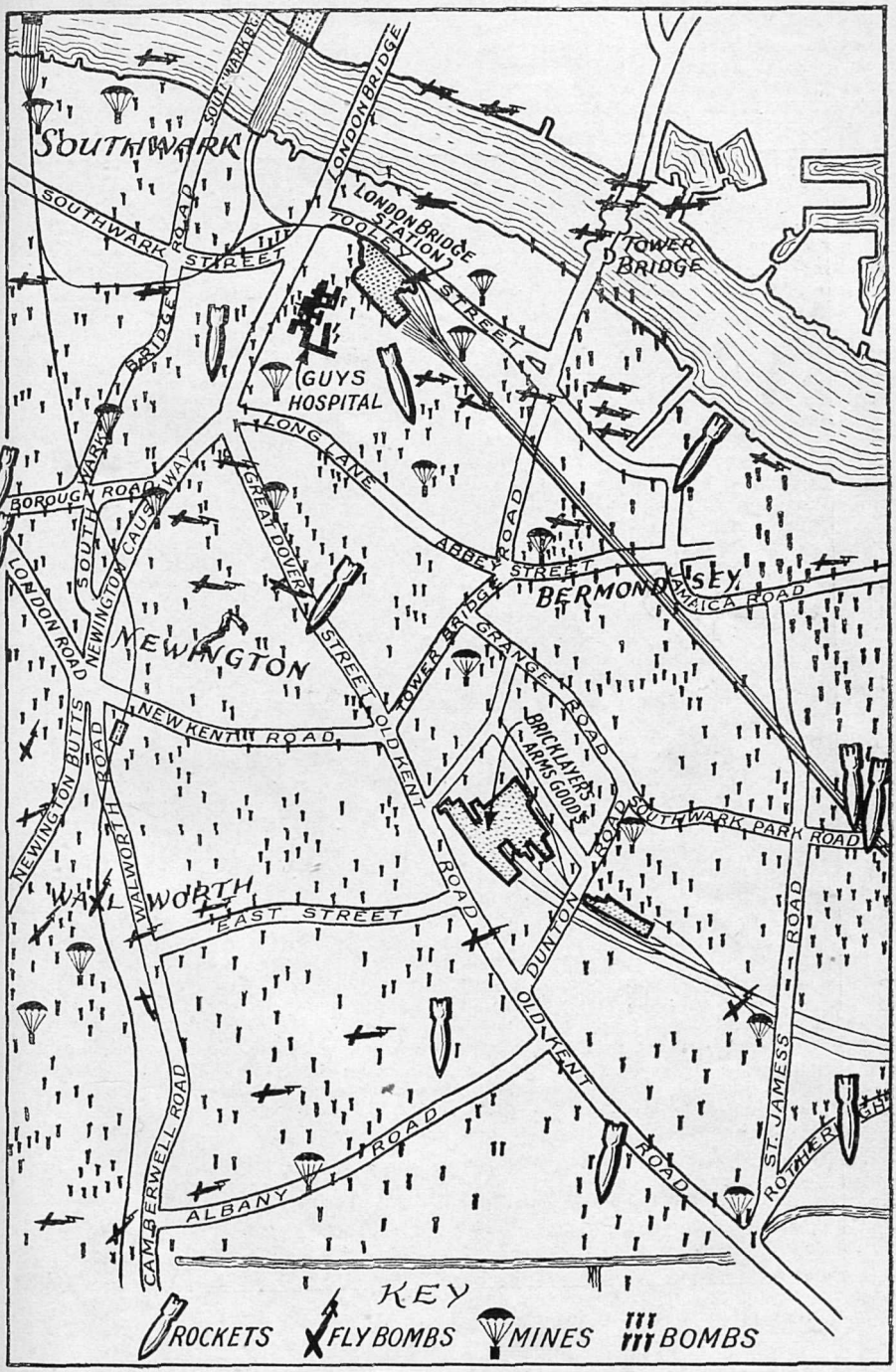
Infantile Osteomyelitis and Suppurative Arthritis.—Infantile osteomyelitis differs from that of older children because the epiphysial line is intracapsular. The lodgment of the staphylococcal-infected clot—a clot which is usually derived from some skin lesion which has healed partially or is in process of healing, ——— in the epiphyseal line therefore takes place within the joint, and the infection is apt to spread not away from the joint to the medulla and up the shaft of the long bone, but towards the cavity of the joint. The disease in infancy thus presents apparently as an arthritis with exudate into the joint. This exudate is sometimes serous appearing because of the near proximity of the focus of suppuration at the end of the long bone within the capsule of the joint, sometimes it is purulent and there is an actual fistulous communication between the joint and the focus of suppuration. Paracentesis of the joint can alone determine the nature of the fluid. The presence of fluid in the joint and of a high fluctuating temperature are the characteristic findings. It is characteristic of this infantile form of osteomyelitis more often than in later life, that we find multiple lesions developing simultaneously, so that several joints may be involved at the same time.

Like infantile scurvy, infantile osteomyelitis is now a rare disease and for a different reason. Formerly the children of the poor, more often than not, suffered from impetiginous sores. The care and cleanliness of the skin of the infant is to-day sufficiently satisfactory to make this complication of staphylococcal skin lesions something of a rarity.

Pneumococcal Arthritis.—Pneumococcal arthritis is very rare except in infancy. As a rule there is a recent history of pneumonia or empyema. The joint does not always suppurate. It is quite usual for a joint, swollen and reddened, to subside of itself. When suppuration does occur it must be treated by aspiration or even incision.

In older children we have to consider other possibilities:—

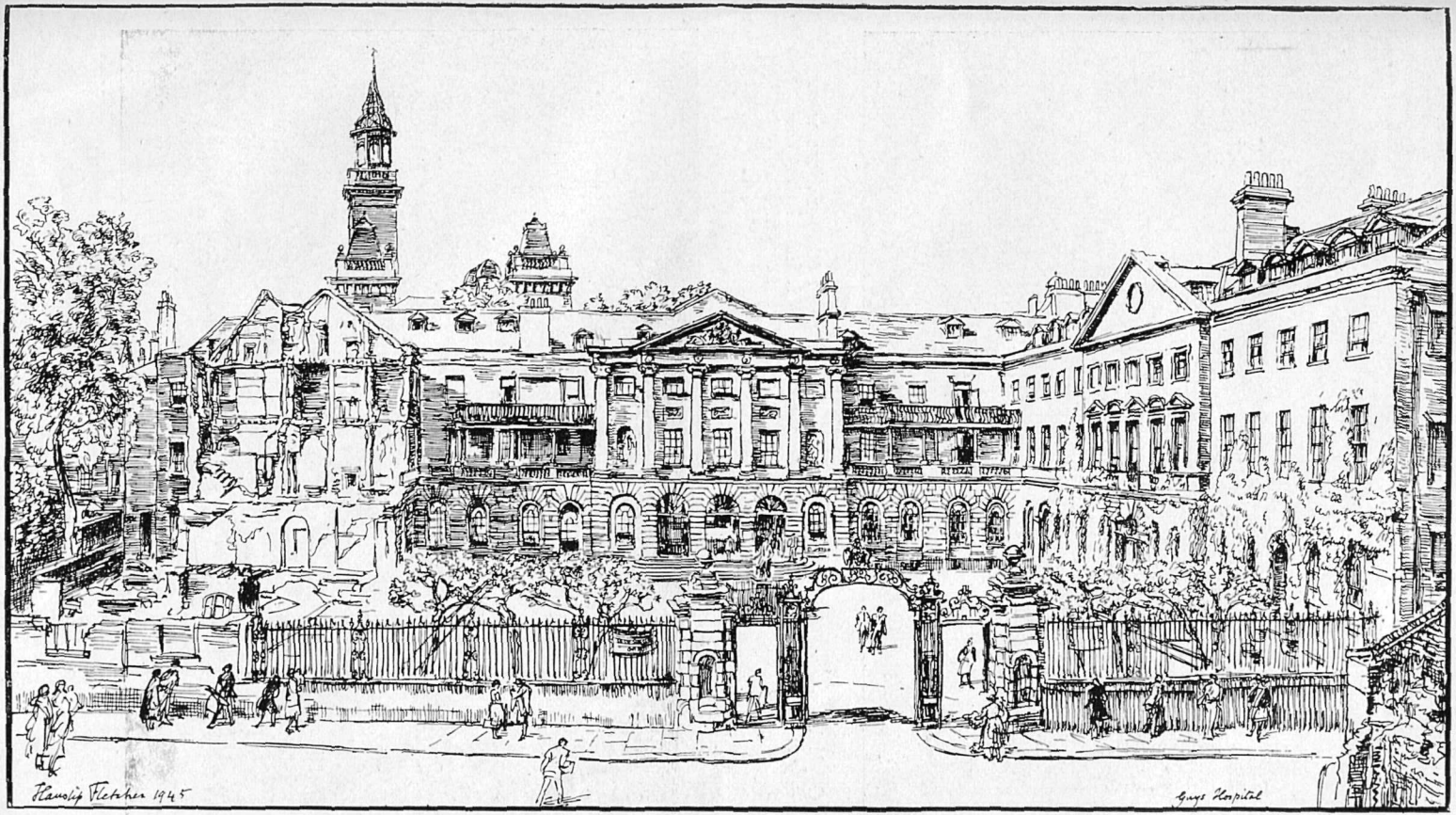
1. Acute rheumatism and osteomyelitis.
2. Growing pains (rheumatic or postural in origin).



Reproduced from a drawing by Nelson Burgess

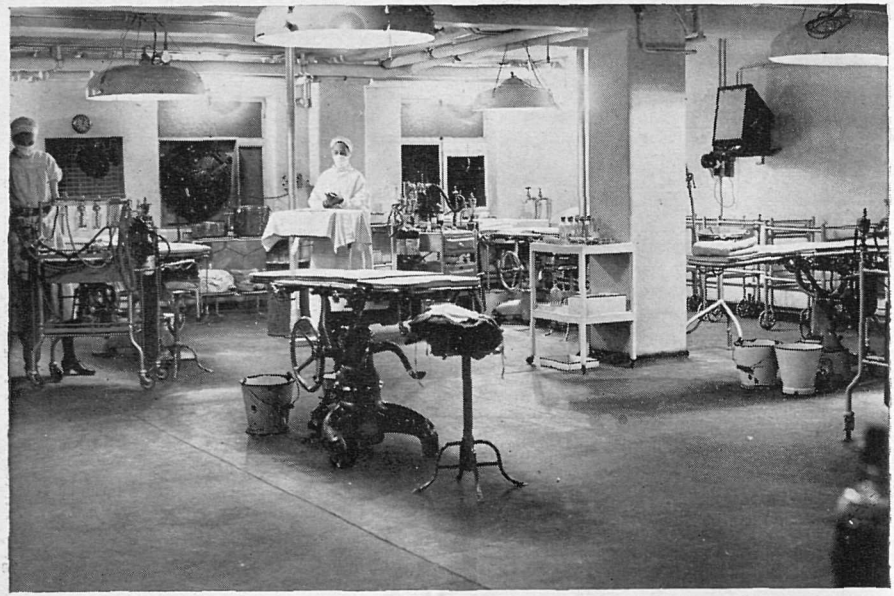
Incident Chart of the area from which Guy's received casualties.
(The area is 1¾ miles square : 963 high explosive missiles fell on it and caused 5,572 casualties)

A view from Hunt's House of the area laid waste by fire on the night of December, 29th, 1940; when the Hospital was completely evacuated.



By kind permission of *The Sunday Times*

Though one of its wings was destroyed, The Hospital still stands largely intact, as Mr. Hanslip Fletcher's pleasant drawing shows.



Guy's War-time Main Theatres where an average of 50 operations were performed weekly—the scene of operations. It is hoped that the old theatres will soon be in commission again.

The Incident Room.

3. Leukæmia (acute lymphatic).
4. Anterior poliomyelitis.
5. Toxic multiple peripheral neuritis.

Acute Rheumatism and Osteomyelitis.—It is not always easy at first to distinguish between the pains of osteomyelitis and of severe acute rheumatism. In osteomyelitis it is true that the pain will, as a rule, be located in the neighbourhood of one joint, while in rheumatic fever more than one joint is involved. Yet there are many cases in which osteomyelitis shows multiple lesions, in which subsidiary and often short livid swellings come and go near other joints in addition to that of the main lesion, while in acute rheumatism at any one moment, though other joints are likely to take up the running later, complaint may be of one pain only. The presence of cardiac murmurs is in favour of rheumatism, but it is well to remember that in osteomyelitis a metastasis of infection to the cardiac muscle, showing itself usually in a pericardial rub, is not unusual and is, of course, a very ominous sign. The presence of rheumatic nodules or of chorea would be decisive. When you are in doubt, it is well to observe carefully the mental state of the child. In osteomyelitis delirium is common. Sometimes the child is obviously toxic, drowsy and confused. In rheumatic fever the mind is unclouded, fully awake to the severity of its suffering.

If, on a local examination, the slighter movements of the joint can be effected, actively or passively, without adding to the pain, if over the bone in the neighbourhood of the joint there is a point of maximum tenderness, if there is œdema and swelling which tends to pass along the line of the long bone, the diagnosis of osteomyelitis is clear. Now that less stress is laid upon the need for immediate operation in osteomyelitis, now that immediate steps to establish complete drainage or to excise the focus of infection have been commonly abandoned, the decision need not necessarily be made immediately and observation for twenty-four hours or so will, I think, always make the distinction clear.

Growing Pains (*Rheumatic and Postural*).—The milder forms of rheumatic arthritis are more apt to be confused with the muscular aches and pains in the leg of which many children complain after long standing or any unusual exertion. The distinction is not easy. If simultaneous complaint is made of pains in the arm joints, certainly the rheumatic explanation is more likely, unless, perhaps, the child has been turning the mangle or a skipping-rope with undue violence. Rheumatic pains are often at their worst on waking in the morning; postural pains are apt to be benefited by the night's rest. Postural muscular aches are eased by massage, and the child likes the part to be rubbed. In rheumatism rubbing is more apt to be resented. But these are indefinite and not very substantial points on which to base a diagnosis.

The child with muscular aches and pains has, as a rule, a faulty posture, with lax and toneless muscles and a body that sags and droops. The child with rheumatic pains is likely to show, on careful examination, some other sign of rheumatic infection. The heart must be carefully examined. Some slight, if intermittent, rise in temperature, a rise in the pulse-rate when asleep (the day-time pulse-rate is too apt to be influenced by such factors as excitement or alarm to be of the same significance), a rise in the sedimentation rate, each of these may be of significance. The presence of rheumativ nodules, of rheumatic rashes or of chorea would end our doubts. Rheumatic growing pains, so called, are common and important to recognise, but, at the same time, aches and pains in childish limbs are of everyday occurrence and must not be taken as evidence of rheumatic infection, with all that that implies, without some confirmatory evidence.

Leukæmia.—We must avoid, too, if we can, making a mistake which I have known occur from time to time—the confusion between leukæmia in its very earliest stages and sub-acute rheumatism. No disease begins more insidiously than acute lymphatic leukæmia. In a few weeks the profound anæmia, the enlargement of the lymphatic glands and the purpuric eruption will, no doubt, make all abundantly clear. But before these things become apparent there is often a period of some weeks' duration when the child is vaguely out of health, and at this time a complaint of pains in the legs is quite common. The diagnosis of leukæmia is in its very early stages as difficult as any I know. At this time even an examination of the blood may leave us in doubt The possibility should always pass through our mind if we are to avoid the mistake..

Anterior Poliomyelitis and Multiple Neuritis.—Remember, too, that anterior poliomyelitis and multiple neuritis may begin with shooting and tingling pains in the legs and with great hyperæsthesia, so that touching or movement is alike painful. I have seen a confident diagnosis of rheumatism made more than once in the early stages of both these diseases. The picture is not really very similar, and if you bear the possibility in mind, you are not likely to make this mistake.

Correspondence

DISEASES OF THE HERD.

To the Editor of the GAZETTE.

SIR,—Somebody once said that the human race is made up of those who rush in and those who fear to tread.

It would be temerity *in excelsis* for one who does not possess Mr. Layton's erudition to criticise his clinical lecture in your issue of July 7th, 1945. As I cannot resist the temptation to do so however, I reveal myself as belonging to the first category.

That the mind of man can and may influence his body nobody seriously doubts. As to how and to what extent are other matters. Incidentally, I would recommend Mr. Layton to read Professor R. J. A. Berry's article in the Proceedings of the Royal Society of Edinburgh, Section B (Biology), Part I, Vol. LXII, on "Some Recent Advances in the Study of the Brain as the Implement of Mind."

In the earliest days when man first began to find it to his advantage to live in communities, it is pretty certain that there were such things as "herd diseases," just as to-day we find foot and mouth disease in cattle. Would it be going too far to regard all diseases of communities as "herd diseases"? Admittedly they may be infectious and non-infectious, epidemic or sporadic. Even pandemic, on occasion. Often endemic.

If I read Mr. Layton correctly, it would appear that he supports the view that certain diseases affecting the community—or the herd, as Mr. Layton prefers to call it—may be conditioned in their incidence, prevalence, or even their nature, *e.g.*, the Black Death, instanced by him, by some state of the mind of the individual or of the community. Something like those brave, but foolish people who believe that "if you're afraid of a disease, you're sure to catch it."

I do not suppose for a moment that the Editor would grant me the space for all I would like to say. For example, Mr. Layton is rather doubtful as to whether tuberculosis may become epidemic. He would have no doubt whatever about it if he could see a cemetery on Keppel Island, which I know well. The graves are all those of Indians from Tierra del Fuego, who were taken to a missionary station on Keppel Island to be "educated." Tuberculosis occurred and spread like a prairie fire. If ever there was an epidemic, that was one. I hope Mr. Layton will not say that it was an example of "herd instinct" and proves his case! Or was it merely "a sporadic infective disease very common in man"?

Does malaria never occur in epidemics? If not, how would the outbreak in Ceylon just before the war be described? Or the epidemic in the Mauritius, when the disease was first introduced there?

There are many potential "world's greatest scourges." Whether they ever become *de facto* scourges depends on their strict control by the authorities concerned and very largely on the maintenance of a high co-efficient of sanitary intelligence in the community by continual instruction and exhortation. It has long been a truism, for example, that the "incidence of enteric fever is an index to the sanitary intelligence of a community."

As for the influence of the mind, the "exquisite sensitiveness of the herd" to certain diseases quoted by Mr. Layton is more likely to be at its worst when the mind is ignorant, stubborn, refractory to instruction yet thinks it knows all it need know. I can agree with him in that.

I am interested to learn that micro-organisms are not the "cause" of infective disease. Nor viruses, I suppose.

I saw an advertisement in the *Daily Telegraph* recently asking that all who believe that the earth is flat would communicate with a box number.

Yours faithfully,

"UNCLE HARRY."

"GUY'S AND THE GERMAN WAR."

To the Editor of the GAZETTE.

SIR,—Dr. Bishop's recent epic article, "Guy's and the German War," must have stirred in the hearts of all the Guy's men and women who read it with a pride in their old hospital and a sense of gratitude to those who through such ordeals have so adequately maintained its highest traditions.

May I add my small tribute to all those who bore the strain of those terrible days? After serving with the B.E.F. in the Army Nursing Service I was fortunate enough to escape when France collapsed and to work again for a short time at Guy's. During the early weeks of the "Blitz" it struck me that the morale and behaviour of the entire staff, to its most junior members, compared (more than favourably) with anything I had seen during the evacuation of Brittany.

But what impressed me even more was the courage and stoicism of the patients. I suspected then, that to be helpless and in bed during a raid demands a special kind of fortitude—a theory which I was able to prove when later I was myself a patient. The people of the Borough, for whom we have long cherished an affectionate admiration, were, under such conditions, little short of heroic. Even when maimed, bereaved or homeless they remained cheerful and philosophic. Neither the roar of the barrage nor the screams of bombs could destroy their sense of humour. They were an inspiration to all those of us and in turn their faith in the Hospital was almost unbounded.

May the Guy's of the future be worthy of that faith!

Yours, etc.,

M. WEIGALL

(formerly Sister Roseveare.)

Sport

Cricket

GUY'S *v.* BECKENHAM.

(*Played on Saturday, August 4th*, 1945.)

Result: Lost. Scores: Guy's, 152; Beckenham, 154 for four wickets.

With the side considerably weakened, due to the holiday inclination, Guy's went to play Beckenham with suitable enthusiasm tempered with a modicum of reserve.

On winning the toss Munro and Lambert opened the innings, bringing the score to 29 before the latter was dismissed. Harvard Davis, Garland and Trist in turn assisted Munro to bring the score to 108 for four, but at this stage Munro was dismissed, having completed a sterling innings of 60 much-needed runs. Our weakness was then revealed, the remainder of the side being able to add only 44 more runs, the last five wickets falling to Phillips for 26 runs. For no apparent reason all the Guy's bowlers had a desire to bowl outside the leg stump which they realised adequately, and consequently Beckenham were able to pass our total with only four wickets down.

Team.—L. D. Carton-Kelly, I. A. H. Munro, A. E. Trist, K. G. Pritchard, F. R. Lambert, W. H. Garland, R. Harvard-Davis, H. M. C. O'Driscoll, R. A. Hancock, C. B. Vaughan, K. Little.

GUY'S *v.* LONDON HOSPITAL.

(*Played on Saturday, August 11th*, 1945.)

Result: Lost. Scores: Guy's, 69; London Hospital, 132.

The London Hospital, bent on avenging their last year's defeat, turned out full strength to meet a Guy's side, a shade short of batsmen. London won the toss, but were soon fighting for runs with the score at 42 for four, Hanworth being the only batsman who was apparently at ease; his 36 was the best batting performance of the day on what was definitely a bowler's wicket. The Guy's bowling was of good length and dangerous throughout, and our opponents were dismissed for 132. Carton-Kelly was the most successful bowler, his five for 28 savoured of accuracy even beyond his usual limits.

The Guy's batting bent and buckled under the attack of Lloyd and Shaddick, Williams with 16 in an hour and a half and Trist with a brisker 17 being the only two to offer resistance. Lloyd and Shaddick returned the figures of five for 22 and four for 22 respectively, and were mainly responsible for dismissing Guy's for 69.

Team.—L. D. Carton-Kelly, I. A. H. Munro, A. E. Trist, J. D. Williams, D. J. Sheerboom, W. B. Webb, W. H. Garland, F. R. Lambert, K. G. Pritchard, H. M. C. O'Driscoll, P. J. Dwyer.

Hospital Information, etc.

Appointments

The following have been appointed Consultants to British Legion Village:—

Surgeon.—Mr. E. G. Slesinger.

Gynæcologist.—Mr. G. F. Gibberd.

Mr. G. F. Gibberd has been elected Secretary of the Royal College of Obstetricians and Gynæcologists.

Dr. J. M. H. Campbell has been appointed Lumleian Lecturer for 1946.

Dr. E. R. Boland has been appointed Croomian Lecturer for 1947.

Pass List

UNIVERSITY OF LONDON.
FIRST EXAMINATION FOR MEDICAL DEGREES.
(For External Students.)
July, 1945.

A. G. Blyth

SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES.
(For Internal Students.)
July, 1945.

H. M. Baird	L. A. Rees
B. Bass	I. Rocker
R. I. Copeland	H. N. St. John
N. S. Galbraith	P. R. Sowerby
E. T. J. Jones	I. B. Thomas
E. C. Lewis	C. B. Vaughan
P. O'Gorman	E. S. P. Williams
J. K. Price	H. Windschauer

The following Candidates have completed exemption from the First Medical Examination :—

M. Lewis	J. A. Payne
W. H. McKendrick	T. I. Rowland

The following Higher School Candidates have qualified for Exemption from the First Medical :—

A. E. R. Buckle	B. Hartley
J. R. Evans	J. A. B. Jones
R. G. Garner	T. B. Kellaway

SOCIETY OF APOTHECARIES OF LONDON.
FINAL EXAMINATION.
June, 1945.

Pathology, Bacteriology and Forensic Medicine.—R. C. Jennings, E. H. Osborn-Smith, G. F. Penny.
Medicine.—R. G. G. Jones.
Midwifery.—*J. Wotton.

* Has completed the examination.

UNIVERSITY OF LONDON.
SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.
(For Internal Students.)
July, 1945.

Pass.

R. J. Aspinall	G. E. Haward
P. Chadwick	J. L. Herbert
K. M. Citron	A. L. Jeanes
D. W. Clark	J. E. H. Lahaise
M. P. M. Coupland	C. J. G. Menzies
J. R. Deacon	C. P. Mills
I. I. Eckstein	J. T. Owen
J. C. Farrow	H. H. Richards
J. Fine	P. T. C. Rowan
J. R. Greaves	A. H. R. Rowe
D. H. Griffiths	J. Vance
M. W. J. Grummitt	P. R. Wagner
M. H. Handoll	J. D. Williams
D. F. N. Harrison	F. R. H. Wrigley

SECOND EXAMINATION IN DENTAL SURGERY.
PART I.
July, 1945.

Pass.

J. L. Attenborough	L. A. Rosen
S. P. Johns	P. H. Smith
A. Levy	W. J. Tulley
R. A. J. Mayhew	

The following Students are credited with Anatomy and Physiology :—

R. McK. Carson	J. H. Keeling
J. D. Derry	P. B. Morris
H. E. Dyer	T. C. J. Price
J. B. Harris	A. A. Robinson
N. R. Howells	

The following Student is credited with Prosthetic Dentistry, including Metallurgy:—

A. W. Hilliam

SECOND EXAMINATION IN DENTAL SURGERY.
PART II.
July, 1945.

*B. M. Bilton	A. K. Parsonage
H. M. Hughes	A. Rooms
D. G. Jones	J. S. Rose
J. G. L. Knowles	P. G. Shingler
S. F. Lamb	

* Awarded a Mark of Distinction.

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.
July, 1945.

Honours.

J. B. Kirkwood

Distinguished in Surgery, Dental Surgery, Operative Dental Suregery.

Pass.

R. A. C. Dove	G. A. Morrant

Supplementary Pass List.

The following Student has passed in Group I :—

C. D. Baker

UNIVERSITY OF LONDON.
M.D. EXAMINATION.
PART II.—Pathology.

Barnet Levin, M.B., B.S.

Change of Address

P. M. F. Bishop, M.D., The Warden's House, Guy's Hospital, S.E.1. (Tel. : Hop. 1177) Residence and Consulting Room.

John D. Buxton, Capt., R.A.M.C., No. 6 Field Surgical Unit, B.L.A.

S. De Navasquez, Major, R.A.M.C., 29 (Br.) General Hospital, B.L.A.

F. K. Escritt, Colonel, R.A.M.C., Medical Branch, H.Q. Guards Div., B.L.A.

P. Hopkins, M.R.C.S., 21, Brondesbury Road, London, N.W.6. (Tel. : Maida Vale 3341.)

H. H. Kenshole, Col., R.A.M.C., 1, Panmuir Road, Wimbledon, S.W.20. (Tel. : Wimbledon 5606 and 3597.)

S. C. H. Lane, M.B., B.S., West Lodge, Wilton, Wilts. (Tel. : Wilton 24.)

A. B. Lee, Surg.-Lt., R.N.V.R., H.M.S. *Formidable*, c/o G.P.O.

Jean M. Mercer, Sisters' Mess, R.A.F. Hospital, St. Athan, nr. Barry, Glam.

N. Mutch, M.D., 84, Harley Street, W.1.

K. E. Pringle, L.D.S., 12, Manchester Square, W.1.

L. K. Robson, M.B., B.S., Herstmonceux, Sussex (Tel. : No. 3102 after Sept. 12th.)

L. F. W. Salmon, Lt.-Col., R.A.M.C., A.D.M.S. H.Q., 2nd District, C.M.F.

J. Tudor (342516), Lt., R.A.M.C., R.M.O. att. 4th G.C. Regt., Tamale, Gold Coast, W.A.C.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1491 *15th September, 1945* *Ninepence*

PASSIM

THE war years have of necessity brought about many changes in the academic life of the student. Consideration has already been given, in these pages, to the many war-time difficulties responsible for these changes, and we do not intend to labour these points any further. Now however, the time has come for reconstruction and for a return to some of the ways of pre-war Hospital life. Very few students of "the present generation" will remember what that life was like; many may not know of some of the admirable institutions present at Guy's whose suspension was made necessary by war and bed shortage.

Outstanding among these was the appointment, every three months, of six senior students as Clinical Assistants. These were usually, though not essentially, men who had just qualified. Each had a number of beds allotted to his care and during his week of "take-in" was allowed to select, from patients awaiting admission, cases which he felt would be of value and interest to him. He was able to treat his own patients and was afforded laboratory facilities for any relevant investigations upon them. This arrangement put him in the ideal position of being able to gain real experience—such as can only be acquired by assuming a large share of responsibility—and, at the same time, of having constantly available to him the mature advice of his seniors on any problem presenting especial difficulty.

It was from men holding this appointment that the House Officers of the Hospital were almost invariably selected. That is to say, a man holding the post of Clinical Assistant was eligible for that of, say, Assistant House Surgeon. Again, those holding the latter post would be eligible for the appointment of Out-patient Officer. The numbers of men holding these appointments were so arranged that there were more Clinical Assistants than Assistant House Surgeons, and more of the latter than there were Out-patient Officers. Hence the arrangement had additional advantages in raising the general standard of efficiency through the element of competition which it brought about, and in providing a very fair system by which the best men obtained the best jobs. Here is a pre-war institution whose re-instatement would be most desirable from all points of view.

Until the war came it was the custom for surgical ward clerks to have a "take-in" rota and, when their turn came, to live in the Hospital for a period of a week at a time. This provided them with an additional stimulus to their interest, with the opportunity of seeing which types of case required admission and with the chance of "following" patients right through, from the moment of their admission until their discharge. Such advantages are, at present, available only to Senior Dressers.

The re-adoption of these measures, and others like them, must be encouraged and their re-instatement effected as soon as possible. Though, in other spheres of life, opinion may have it that progress towards post-war reconstruction is slow or half-hearted, let it never be said that Guy's was slow in "picking up the threads."

WE announce with regret the retirement of Sister Shield from the Dental Department. Her association with Guy's has been a long one, dating back to 1904, when she was a probationer. A sister here from 1909 to 1923, she returned to Guy's in 1936 after some years abroad. We wish her every happiness in the future.

WE also announce the departure of Mr. E. Chapman from the Stores Department of the Superintendent's Office. He has been at Guy's for the past forty-one years, and we hope that such a memorable record of service will be rewarded with many pleasant years in retirement.

WE make no apologies for including in this issue Puggly Pani's letter, which has been unavoidably delayed. While, strictly speaking, it can no longer be considered as topical, we feel that it will be of general interest, especially bearing in mind the fact that our responsibilities with regard to the Far East are by no means over yet.

Psychological Medicine and the Family Doctor

A Lecture delivered at Guy's Hospital by R. D. GILLESPIE, M.D., F.R.C.P., D.P.M., Physician for Psychological Medicine, Guy's Hospital.

THE opening of the York Clinic for Psychological Medicine at Guy's is an opportune moment for discussing the applications of psychiatry to general practice. The need for doctors to pay attention to the psychological aspects of medicine has been recognised more and more in the past two decades; but tradition dies hard, even if it is not a very old tradition, and there is still reluctance on the part of many to take any lively interest in psychiatry. The curriculum is partly to blame. Although there was a curriculum conference not many years ago it did not succeed in producing more than recommendations that the teaching of psychological medicine should be supplemented in certain ways. The compulsory part was still left at attendance at lecture-demonstrations in a mental hospital. The fact that mental hospital patients are only part, and numerically a minor part, of the domain of psychiatry was not recognised by making anything else compulsory, nor was it made obligatory to have at least one question in the field included in the final examination. When a sub-committee of the British Medical Association surveyed the field of education in psychological medicine nearly twenty years ago it was discovered that one university in the Empire went so far as to include psychiatry as one of the subjects equivalent with medicine and surgery in the final examination. Now Edinburgh has followed suit at the request of the students themselves. This observation should be printed in italics. But, as Mr. Slesinger often points out to me, with some envy perhaps, the Scottish student is a far-seeing person.

PREVALENCE OF PSYCHOLOGICAL DISORDER.

It would be very much to the advantage of medical men generally that more teaching of this sort should be available, not only in the interests of their patients, but often in their own. To show how much the psychological aspects of disease matter, it is only necessary to quote the results of investigations that have been made in recent years. At Guy's Hospital, for example, it was found that one-sixth of all those who turned up at general medical out-patient departments were not suffering from any organic disease, but from symptoms due to psychological causes. The series of Dr. Bruce Pearson's included over 1,200 cases, and has been supplemented at the same hospital by a study of a further 500 cases by Squad.-Ldr. A. M. G. Campbell, who found that 13 per cent. were suffering from psychological disorder. Where illness of the more chronic type is concerned the proportion has been found in 1,000 cases to be approximately 35 per cent. This was the figure arrived at by Halliday, acting as medical referee in a district of Scotland. These data are obtained from clinical material of the type that would as a rule appear in general practice.

Where a consulting practice is concerned the position is not very different. Professor J. A. Ryle told me some years ago that anxiety neurosis was one of the most frequent diagnoses he had to make, and Air Vice-Marshal Conybeare is of a similar opinion—at any rate, so far as war medicine is concerned.

PRESENTING SYMPTOMS.

These figures do not mean, of course, that the patients always or even usually come with their symptoms formulated in psychological terms as depression, worry, or what not, although it is my impression that on the whole they do so now more frequently than they did in the past. Whereas formerly they were apt to complain almost exclusively in terms of physical discomfort, it seems more common nowadays for them to say that they feel nervous or that they cannot concentrate or that their memory is bad. This is probably correlated with the decrease of gross hysterical symptoms in the form of paralysis, blindness, etc., as opposed to frank anxiety states, which have been relatively more frequent in this war in contrast to the last—a difference which some have sought to explain in terms of an alteration in war conditions, but which merely parallels a change that has occurred in civil practice in the intervening twenty years. The late T. A. Ross remarked the same thing in one of his reports of the work of the Cassel Hospital—that in the course of the years it had seemed to him that there had been less tendency for neurotic patients to emphasise bodily complaints

and more inclination to talk in terms of fear and worry. I have received very much the same impression in both civil and military practice, and I have sometimes longed for the good old days when paralysed limbs and anæsthetised senses could be demonstrated in Sir Arthur Hurst's graphic manner to both patient and student, and when there was often something much more tangible to get hold of than a phobia or a blank depression of spirits. The change depends partly on public education and partly perhaps on doctors themselves knowing more about these matters as a result of advances in pathology on the one hand and in psychopathology on the other. The discovery of the Babinski reflex made it much more easy to distinguish organic from functional paralysis, just as other discoveries made it impossible for doctors to speak of Parkinsonism any longer as a "functional" disease, as Gowers did in his famous text-book.

"A ROSE BY ANY OTHER NAME."

It still happens, however, that a physical diagnosis covers a fundamentally psychogenic condition. Such diagnoses as "debility," "anæmia," "rheumatism," and "gastritis" are apt to be labels for what is really a psychoneurosis. Years ago Dr. Millais Culpin showed this very well when he produced a statistical table of the incidence of these alleged conditions in a large industrial concern. Taking the sick returns year by year, he found that when the number of diagnoses of anæmia, gastritis, and dysmenorrhœa went up those of neurasthenia, "nerves," and general debility went down; in other words, these are often interchangeable labels. Recently war experience has provided a further illustration of the same thing.

When a special unit was opened for the treatment of rheumatism it was found that more than one-third of the cases sent there were not rheumatic at all, but were psychoneurotic in some sense. For example, a man aged twenty, whose case was described to me by Wing-Cmdr. J. Flind and Squad.-Ldr. Barber, had complained of the fairly sudden onset of pain in his shoulder-, hip- and knee-joint on the left side, about nine weeks before admission, associated with attacks of dyspnœa, palpitation and dizziness. He had breathlessness and palpitation, but no pains, before entering the Service. When he joined up he was given disciplinary training; he felt very low in spirits, complained of aches and pains, and was put to bed. Being allowed up, he was transferred to another station, where his symptoms soon reappeared and he was sent to bed again. It was found that he had always been an excitable worrying person more or less afraid of the dark and upset by the sight of blood; his mother was herself nervous. His symptoms appeared in the Service when he was put to a type of training which he disliked enormously, and reappeared when he was put on guard duty, which he disliked still more. He said frankly that he was "scared stiff of these guards." He had no physical signs, and the only positive findings were psychological ones.

The same thing holds in many cases of appendicitis in which a normal appendix is found on operation. I still remember vividly the first case of this sort that I had under my eye as house-physician. I was not trained in psychological medicine then; but this man's appendix was quite normal, and I noticed during his convalescence that he was inordinately fond of self-display, wearing a gaudy dressing-gown, which he might be said to flaunt in front of the nurses as he strolled about the ward. I have no doubt now that had I known something of psychological medicine then one unnecessary operation could have been avoided. We all know of teeth taken out unnecessarily, on the assumption that symptoms, really psychogenic, were due to dental sepsis; of refractive errors of plus one or minus one dioptre corrected by glasses but without ultimate relief of the headache, which was due to anxiety of some sort; and of exploratory laparotomy with negative findings in, say, a depressive illness.

PSYCHOSOMATIC MEDICINE.

But it is not only conditions mistakenly diagnosed as physical that are to be accounted for by psychological factors. The term "psychosomatic medicine" covers also conditions which have a definite peripheral pathology of structure, but in which psychological factors are important, sometimes the most important, determinants; for example, in some cases of asthma, of certain skin diseases such as prurigo, of duodenal ulcer, and of hyperthyroidism.

Not long ago I saw a man with a fairly widespread pruriginous eruption, which had been very persistent and was associated with a good deal of depression of spirits and insomnia. Repeated and vigorous treatment for his skin did not have any lasting effect. It was then found that his symptoms had begun when he was sent abroad on service and that his going abroad was only the last of a series of efforts to get into a

really dangerous enterprise, although he was certainly over the age at which front-line service was usually permitted. He had volunteered for two of the most risky forms of service and had been refused these on account of his age. It was curious that he should have been so unusually persistent in seeking danger. It transpired that he had a sense of shame for having developed neurotic symptoms in the last war so that he was invalided home; furthermore, he had a great admiration for, and at the same time considerable fear of, his father, who was a very severe man with an impulsive temper. A sense of unworthiness acquired *vis-a-vis* his father had made him want to live to please him. This apparently was the main driving force of his life, and although he was married and had a family his great desire was to justify himself in what he thought was his father's opinion, and it was this that caused him to volunteer for the dangerous jobs. In actual fact the attempt to face the rigours of a campaign had made him tense and nervous, had upset his health and helped to bring on his skin eruption, and kept him miserable at what he considered his failure. Discussion of this attitude and the realisation of its immaturity enable skin treatment to proceed with final success.

Another patient with impetigo which was suspiciously persistent turned out to be suffering from acute apprehension about return to duty—not because he was a coward, but because he had had an extremely disturbing experience which had stamped itself on his mind in a way that made him feel it was impossible to face a recurrence of the same situation, although previously he had behaved with courage and devotion.

It is possible to show that asthma has all sorts of relationships to mental events; that hyperthyroidism is especially apt to occur in people who have been anxious over a long period; and that rheumatoid arthritis is found more often in people whose emotional furniture is disarranged. Naturally the relationship of the pathological bodily state to the psychological aspects is a very varied one, but the simplest is where the precipitating factor is psychological—for example, in asthma sustained by an unhappy domestic situation, or, as Rogerson showed, in children in whom the development of asthma may be precipitated by an over-anxious parental attitude.

MEDICAL SCEPTICISM.

It is of course natural for anyone approaching the problem from the angle of general medicine to be very sceptical about the relationship of psychological disturbance to what is obviously physical disease. I remember a meeting of the Asthma Club many years ago, when it was obvious that some of the members were extremely resistant to the suggestion that an asthmatic attack could be precipitated by an idea just as much as by an injection of something. But appreciation even of the "conditioned reflex" process would have prevented anyone being surprised by this.

The story of the woman who had an asthmatic attack on seeing a bouquet of artificial roses has been paralleled a number of times; for example, in the case, recorded in an American journal, of a woman who was allergic to onions and who immediately developed conjunctivitis and a stopped-up nose on seeing, apparently, onion peelings on the rug. On withdrawing to another room she told the maid that there were onion peelings on the floor and they had made her sick. The maid apologised and said they would be removed immediately, but soon returned and said that they were the remains of a narcissus bulb which a dog had chewed.

This type of thing is one of the simplest examples of the effect of a pyschological fact on what looks like an entirely bodily ailment; but it is worth knowing that a great many more complicated psychological patterns—for example, a domestic situation—can have the same effect. It has also been noticed that a psychological upset, or at least a period of psychological tension, often precedes the appearance of a duodenal or even a gastric ulcer.

TERMINOLOGY.

The general practitioner is apt to treat psychiatry as an esoteric mystery, and this is probably in part the fault of the professors of the subject, but not entirely so. Many doctors profess to be deterred by the terminology, but I am inclined to think that this is a kind of rationalisation for a refusal to become interested. Actually there is no branch of medicine where the general practitioner is more fitted to undertake or in which he has more opportunities. First, as to the objection about terminology: the best practical work in the English language about the psychological treatment of

patients is T. A. Ross's "Common Neuroses." It is written in the simplest English, and there is hardly a technical term anywhere. It describes mainly psychoneurotic conditions. But if the terminology is taken as a whole it will be found—for example, in a standard text-book of psychiatry such as Henderson's and mine—that so far as syndromes are concerned not more than half-a-dozen names are necessary for classification purposes, and of the half-dozen major groups the most outlandish designation of the lot (namely, schizophrenia) has become almost a household word—thanks, it is true, largely to the sensational Press. It is only when you come to psycho-analytic terminology that much special knowledge is required; but the psycho-analytical method is highly specialised, and as it is of practical use, for a variety of reasons, only in a minority of psychological illnesses this problem need not trouble the general practitioner.

SPECIAL OPPORTUNITIES OF THE FAMILY DOCTOR.

On the positive side the family doctor has certain advantages. First and foremost he has, or should have, a good working knowledge of human nature. General practice is one of the best training grounds in that subject. Psychological illness is, roughly speaking, a matter of human beings in personal distress, very often because of their ignorance, shortcomings, disappointments and dissatisfactions, and still more often because of their fears. The study of human nature is therefore profitable not only in teaching one how to handle one's patients but in knowing how to cure, or at least to help, anything from one-sixth to one-third (some would say more) of the illnesses for which they consult their doctor. In this sense anyone who cares to study this topic is capable of becoming a psychotherapist up to a point, although few people will deny that the best psychotherapists are born as well as made. It is, however, to be expected that so long as doctors as a whole tend rather to shun the psychological aspects of their practice, the number of irregular practitioners in this field is likely to be considerable. Many of the triumphs of those who practise suggestion in various disguises are achieved in patients in whom the doctors have not recognised the psychological basis for their illness. The medical man, however, has certain advantages of his own, although his very knowledge prevents him having that sublime confidence which comes so naturally to the quack. In the first place, the psychological distress which the patient is suffering expresses itself very often in terms of bodily discomfort—indigestion, palpitation, and so on—and only a doctor is in an authoratative position to evaluate such symptoms. Unfortunately, medical education tends to over-emphasise the structural aspects of pathology. It is a pity that the student's physiological work does not concern itself a good deal more with the effects of the emotions on the bodily functions. He might then never forget that when symptoms of a disturbed organ are presented to him one of the causes that he must always remember is the emotional or psychological one. This, however, is the last that he usually thinks of, and a great deal of time may be spent on laboratory investigation before the patient is even asked whether he is worried or not. Psychological factors are so pervasive that they should enter into consideration in almost any differential diagnosis in the first instance. This, at any rate, would be safer than not considering them at all.

SUGGESTION.

There is another advantage that the doctor possesses. Like the priest he is a symbol of mysterious power in the eyes of his patients, and has in consequence a great capacity for allaying anxiety. We are apt to forget how thin is the veneer of culture and adult control, and how often in times of distress, especially if the distress is fundamentally distress of mind rather than of the body, people tend to think in primitive terms. It is in such circumstances that suggestion is particularly potent; yet few doctors consciously practise suggestion, although they are in a position to use a very enlightened type of it since they combine the authority conferred on them by the more childish aspects of their patients' minds with the enlightenment contributed by their own education in disease.

I am not advocating that suggestion as such should be widely used; yet it is more appropriate for the ill educated, and is sometimes the only form of psychological treatment that is applicable to them. How powerful it is is illustrated by the famous story told by Dr. John Brown, of Edinburgh, who reported the case of a labouring man affected with colic, for whom he prescribed some medicine, directing him to take it and return in a fortnight, assuring him that he would be quite well. At the appointed time the man returned, entirely relieved and jubilant. The doctor was gratified at the manifest improvement in his patient's condition and asked to see the prescription

which he had given him; whereupon the man explained that he had "taken" it, as he had understood the directions, by swallowing the paper!

EDUCATION AND SUGGESTIBILITY.

I used to think that the more educated people were the less suggestible they became, but this is certainly not at any means always the case. Many years ago I acted on assessor for the Asthma Research Council to a doctor who claimed to cure asthma by suggestion. I selected twelve asthmatic patients for him, and he proceeded to use his method in my presence. He employed what to my mind was a very simple form of suggestion, and after one session three of the twelve patients proclaimed themselves better, and these were certainly among the most intelligent of the small group. Similarly, Professor Witts and his co-workers found at the Asthma Clinic at Guy's that they had almost as much success for a time with injections of distilled water as they had with vaccines and the like.

The point is that suggestion is the simplest of form psychotherapy and does not require a technical knowledge of psychopathology in the modern sense. The family doctor is in a peculiarly good position to apply it, because of his special prestige with the patient. It is true that he uses suggestion all the time, more or less unconsciously, when he gives a bottle of medicine or some other treatment that he himself has faith in, but deliberate and discriminating use of suggestion as an additional weapon is at present rather neglected.

IATROGENY.

There is a negative aspect of this matter of suggestion which is not so much to our credit. There is a chapter omitted from medical text-books which might be headed "Iatrogenic Diseases"—that is to say, diseases produced by doctors. It is not well enough realised that it is dangerous to give a label to a set of symptoms of disease until you are convinced that it is the right one. If a syndrome is psychologically produced (which, of course, the patient does not know), and if the doctor also does not know this and calls it gastritis because the patient complains of indigestion, or a weak heart because he complains of breathlessness or precordial pain, or even if he attaches to it some cabalistic letters such as D.A.H., then he has implanted a suggestion in the patient's mind which fixes his anxiety in a way which, if not quite indelible, is at any rate very hard to undo.

The advance of clinical knowledge has definitely limited the scope for iatrogeny. The number of young people who were made into chronic semi-invalids by the diagnosis of a "weak heart" on the strength of a complaint of breathlessness or palpitation, or, in the pre-Mackenzie era, on the basis of a murmur, must be very much less than it was; and though no doubt we have all encountered a case or two of the sort, colitis is not diagnosed on such dubious grounds now as in Axel Munthe's day. "Dropped kidney" is not heard of any longer as a cause of general ill-health, but the old notions of "dropped stomach" and "dropped colon" die hard in spite of Hurst's demonstration years ago that a significant proportion of Guy's winning fifteens carried their stomach nearly in the pelvis. One still finds an occasional belt festooning the abdomens of neurotic patients. A prop of that sort only fixed the patient's conviction that he is physically incapable. All diets and regimes, and often medicines, that are not founded on definite physical findings—not necessarily X-ray or laboratory findings, but those based on a satisfactory clinical history and examination—are apt to produce the same result. This is even truer of operations that have been performed unnecessarily. The experience of such an operation is very impressive, and it is difficult for the doctor who comes afterwards to convince the patient that his symptoms are psychogenic, and rather unhappy for the doctor who has the task of somehow getting over the fact that a colleague of at least equal standing has gone the length of operating. I have known such operations to be performed for broken hearts, angry fathers, sexual guilt, depression of spirits, anxiety of all sorts, and even on account of mistaken pride—the patient herself knowing that she had no physical ailment really, but lacking the courage to tell her parents that she had simply been giving a demonstration and was not ill at all. In that instance the play went on and the appendix came out, and the patient was no better a character afterwards, but rather the reverse. It is, however, only fair to observe that the number of operations performed in the mistaken belief that an organic cause exists, when the condition is really psychogenic, is less than is sometimes supposed, as L. H. Ziegler has shown.

(To be continued)

(Reprinted by kind permission of BRITISH MEDICAL JOURNAL.

An Appreciation

ALFRED SALTER, M.P., M.D.

ALFRED SALTER and I were Obstetric Residents together in the late 'nineties, and we remained close friends afterwards, though lately our contacts have not been numerous.

I remember visiting Salter when he was doing experimental pathological work at Sudbury, and I still seem to hear that honest, hearty laugh and see those dangling legs astride an immense immunised horse; but scientific work did not hold this lover of the "under dog."

We met next in Bermondsey at the Settlement under the Scott Lidgetts, and shortly afterwards he presented the profession with the spectacle of a gold medallist of the London University carrying on a sixpenny evening surgery.

His advocacy of rigid teetotalism and his religious and humanitarian work in a really "darkest London" area brought him both support and opposition, as also did his crusade in the cause of non-militarism.

I met him several times in Switzerland, tearing over passes, seeking change and a higher level of physical fitness than could be found in the Borough.

My meetings with Salter always gave me an enhanced appreciation of my fellow men; his moral courage, tenacity of principle, his unswerving championship of the working man, and his uncompromising determination to follow the right as he saw the right, impelled in many, myself among them, a recognition of greatness.

Salter was ever a fighter, but the issue must be a moral one; in the Press one read of his exploits in the House of Commons. His political life, however, was outside my ken, and I remember him chiefly as a colleague of my early years and one in whom one found so much to admire even when one did not always agree.

If immortality is the perpetuation of a moral influence, then indeed Salter is an immortal.

A. W. O.

Malaria at Guy's

BY A.B.S. AND P.R.A.M.

DURING the last few weeks four cases of malaria have been seen in the Surgery and three have been admitted to the wards.

Before the war malaria was a rare disease at Guy's, only fifteen cases being admitted in the fifteen years preceding the present war, and in five consecutive years in the early 1930's no case being admitted. It is significant that the peak year of the century was 1919, when seventeen cases were admitted. Due to war-time difficulties, access to the Hospital records since 1939 is not yet possible, but only a few cases can be remembered.

Case I.—James B., aged forty-three, was admitted under the care of Dr. Douthwaite. While serving with the R.A.F. in Burma he had his first attack of malaria in March, 1945; this was a mixed benign tertian and subtertian infection; and a second bout on the way home in May. Two days before admission he had an attack of shivering, then became hot and finally perspired freely. On the day that he came to Front Surgery he had a second attack, B.T. parasites being found in his blood smear and his spleen being palpable. The man was admitted and treatment started.

Case II.—Arthur H., aged forty-two, was admitted under the care of Dr. Marshall. He had served with the Royal Artillery in Burma and had been apparently fit while taking a prophylactic dose of mepacrine, which was continued until he left the malarial area. Twenty-eight days later his limbs ached and he felt ill. On arrival in England he perspired freely and had shivering attacks but in view of his colour he was diagnosed as "jaundice" by his doctor and treated symptomatically, after which he was transferred to St. George's, where malarial parasites were found and a full course of treatment was given. Three months later he came to the Surgery with a second attack. Parasites were found in his blood films overnight and he was admitted the next morning. His temperature rose to 103 deg. on each of the first two days and

then fell with treatment. While he had no rigors but he sweated profusely at the height of each attack. No spleen was felt, but his skin and conjunctivæ were strikingly yellow.

The points of interest in this case are :—

1. The benign tertian malaria, suppressed by the regular taking of mepacrine, manifests itself when the mepacrine is discontinued.
2. The yellow colour of the skin and conjunctivæ due to taking mepacrine. This is not due to a toxic action on the liver, but to deposition of the dye in the dermis. It is said to last as long as sixty-nine days. The colour was sufficient for the doctor to treat this man as "jaundice."
3. That in the B.T. infection, he ran a spike of temperature on two successive days. This was attributed either to a mixed infection or to the fact that B.T. infection sometimes starts off with a quotidian temperature.

Case III.—Alfred J., aged thirty-four years, was sent into Guy's as an acute appendicitis. He complained of persistent epigastric pain during the day and the doctor had found tenderness and guarding in the R.I.F. He also had had a headache and feeling of depression and, during the latter part of the day, had sweated. In the last nine years he had twenty-two attacks of malaria, which started with headache, depression, pains in the limbs, and then the typical sequence of a rigor, etc. On admission his skin was moist, tongue furred, and temperature 99 deg. There was tenderness in the R.I.F. and right side of the abdomen, and muscular guarding which was not constantly present; the spleen was not palpable, R.E. showed nil. The history and clinical findings were not typical of appendicitis. Consequently a blood-film was taken and showed B.T. parasites. On the inception of treatment the abdominal pain disappeared.

This case resembles one that was seen two years ago. A French soldier was admitted as a case of acute appendicitis. His French not being readily comprehensible no adequate history had been taken. The diagnosis in this case was first suggested by an easily palpable spleen; he then admitted he had just returned from West Africa and malarial parasites were found in a blood smear.

The anticipated increase in malaria has already been noticed throughout the country. These cases presented well-recognised features, but they were thought worthy of recounting as a reminder that examination of the blood smear is no longer an esoteric investigation and that malaria is not confined to the Tropics.

We are indebted to Dr. A. H. Douthwaite and Dr. G. Marshall for permission to publish details of these cases.

Correspondence

FACILITIES FOR STUDENTS.

To the Editor of the GAZETTE.

SIR,—Before we are completely carried away with new plans, new ideas and new schemes, may we re-institute a few of the facilities available to students before the exigencies of war removed them ?

I refer particularly to the clinical laboratory which was situated "on the top floor of Hunt's House and was open to students daily for the purpose of making microscopical examinations of blood films, urine deposits, etc., in connection with the patients in the wards." I quote from the Hospital prospectus.

It is obvious that this laboratory could not be situated in its original site. But could not the Clinical's Room, between the second and third floor in Hunt's House be rapidly adapted ? The room has suffered little damage and only requires the transference of some equipment from other parts of the Hospital.

The value of such a laboratory would be enormous. From a merely physical point of view it would save the long and exhausting walk from the fifth floor of the Pathology block and back again, which is at the moment necessary for any blood examination. From an academical and practical viewpoint, it would be of even greater value. How many students now in the Hospital know, from practical experience, the microscopical characters of renal epithelium, of the various tube-casts or of the many urinary crystals ?

As an improvement to be introduced into this laboratory, I ask whether it would be possible for a slide of each specimen (biopsy and autopsy) cut during the week to be sent across so that students could examine them in the subsequent week. Surely this would entail little extra work, as, presumably, multiple sections are mounted of which only one is needed to be kept permanently? A plea of the shortage of glass slides would be futile in view of the hundreds that are lying about in the old Morbid Histology laboratory.

Yours, etc.,

M. D. WARREN.

Guy's Hospital, S.E.1.

DUTIES OF REGIMENTAL MEDICAL OFFICER.

To the Editor of the GAZETTE.

SIR,—Owing to several moves, the inevitable "exigencies of the Service," I have just received your issue of December 23rd, 1944. In it your correspondent, Captain R. G. Ticehurst, has written an article entitled "Impressions of India," in which he outlines the duties of the regimental medical officer, and this letter, although somewhat belated, may, I hope, serve to correct some of the impressions your readers might have gained. I feel I can speak with a knowledge of the subject, for I have served as an R.M.O. with a British infantry battalion from the Imphal Plain, through Mandalay down to Rangoon. Now that the war in Europe is over, my lot will undoubtedly befall many a newly-qualified Guy's man, and I trust that my remarks may be both timely and useful.

Unless you are a specialist, your chances of staying in a hospital in India or South-East Asia command for any appreciable length of time, are remote. You may be posted on arrival to a peacetime hospital station in India such as Poona or Secunderabad, but sooner or later you will receive the usual blunt typewritten note requesting your more active co-operation in a far less desirable place than peace-time India. And so your Odyssey begins. You may first go to a jungle training school, where an attempt is made to initiate you into the art of living in the jungle under somewhat harassing and certainly very primitive conditions. Or you may be sent directly to a casualty clearing station, a malaria forward treatment unit, a mobile surgical unit or a field ambulance. The young A1 M.O. with no specialist training generally finds his journey's end, temporarily at least, in the last mentioned, and it is here that he will get his first taste of real "*pukka*" warfare. More often than not he will find himself well up by Brigade H.Q. at times even more forward than this, and he will have to render first-aid to every conceivable type of casualty as the battle progresses. He will not have much opportunity to worry, however, since he will certainly have all his time cut out in filling up forms.

But one day your O.C. gets a request for a new R.M.O. down in one of the battalions in the brigade. Perhaps the last R.M.O. is waiting to go off on a well-earned leave, or perhaps—well, just perhaps! Anyway, if you are lucky enough, down you'll go. I say "lucky" because it is only as an R.M.O. that a doctor in the Army really feels his position. His word on matters affecting the health of the men is law. Not even the O.C. of the battalion can gainsay him. He has a great responsibility to every officer and man under his care, and if he decides for example, that a particular man for any special reason shall not go into action, then the man does not go, regardless of any prior operational requirements. He himself will reconnoitre the site for his regimental aid post; he will march with the men; he may even go out on long-range fighting reconnaissance patrols with the men, and occasionally, he may be required to undertake the full duties of a regimental infantry officer. It is a very full-time job, and as I say, one of great responsibility.

The equipment of the R.M.O. is limited. All he needs is morphia, a scalpel and a few field dressings. His chief job during action is to assess the degree of injury, the type of evacuation—mule, jeep, etc., and to supervise generally the work of the R.A.P orderlies. During a quiet period of course, he has to take the usual sick parades and do all the treatment himself—toe-nails, N.A.B. injections and so forth—since the R.A.P. orderlies are not R.A.M.C. but infantry. Captain Ticehurst speaks of the various books and instruments you require. I strongly advise any prospective R.M.O. not to burden himself with any. Marching along in a temperature of 115–125 deg. F. with a full pack of jungle rations, a couple of water bottles and certain other articles frowned upon by the Geneva Convention, is quite sufficient hardship, I can assure him.

But what are the chief worries of the R.M.O. of an operational unit in the Far Eastern theatre? They are two in number: water firstly, and then the ever-present malaria. During our advance down the Lower Chindwin River, the Japanese had a nasty habit of adding kerosene oil to the wells. Accordingly, we had to drink Chindwin water. This we chlorinated and detasted and, in spite of its dirty colour and brackish tang, it served us well for many days to come. It might be just as well to add that heavily chlorinated water is quite a good emetic, so that detasting thiosulphate tablets are invaluable.

Malaria was at one time the greatest decimator of armies in this theatre, but now that anti-malarial precautions have been brought to such a high pitch of perfection, we have eliminated it as a large factor in casualty-production. It is the responsibility of the R.M.O. to see that these precautions are carried out punctiliously as far as circumstances permit. At times it is difficult. A man does not like to sleep under a net when there is every chance that his slumbers may be suddenly disturbed by a Jap "jitter party." So the taking of suppressive mepacrine to keep the disease in abeyance becomes a religious duty and one which the R.M.O. must watch closely.

As Captain Ticehurst suggests, a knowledge of tropical medicine is useful, but it is by no means the be-all and end-all. Malaria and dysentery are very common, it is true. Leishmaniasis and the extremely interesting diphtheritic "jungle sores" are also relatively common, as are infective hepatitis, dengue and worm infestations. But plague, yaws, cholera and Asiatic small pox are very seldom encountered except as epidemics among the native population. Most of the R.M.O.'s time is spent in dealing with ordinary "European maladies" such as colds, coughs and pains in the head. Personally, I was never given a course in tropical medicine and, as an R.M.O., I have not found it to be a serious handicap.

When a unit is static in a base area, then an R.M.O. can enlarge his sphere of activity. He can start worrying about snakes and latrines and the like. But the R.M.O. really "on active service" has other and far more important things to think on. And when his leave comes around, the attractions of the coolness of Darjeeling or Ootacamund are far greater than those of a reading-room in the University of Calcutta.

And so, young man, if you are destined to become an R.M.O., then the very best of luck to you! I think you will enjoy it. I did. You meet the finest man in the world, the backbone of any army—the infantryman. You will not be sorry, for it is a great experience.

Yours, etc.,
"PUGGLY PANI" (S.E.A.C.).

Sport

Cricket

GUY'S *v.* CANADIAN MILITARY H.Q.

(*Played at H.O.P. on August 19th*, 1945.)

Result: Drawn. Scores: Guy's, 152 for seven; Canadian Military H.Q., 127 for seven.

Playing Canadian Military H.Q. Guy's won the toss and against some mediocre bowling indulged for a change in some fast scoring. Munro was first out with 30 out of 37 to his credit, and Williams then joined Trist to bring the score to 75 before Trist was caught, having made 22. Williams went on to make 59 and, aided by Garland and O'Driscoll, brought the score to 152 for seven, enabling Guy's to declare.

The Canadian batsmen were steady, Andrews in particular playing a good innings before being out for 48. On his leaving a collapse followed, O'Driscoll being mainly instrumental, and at this stage a decision seemed possible in our favour, but our hopes were dashed by Stacey and Thomas, who played out time. At the close the Canadians were 25 runs behind with three wickets in hand. O'Driscoll ended the day with four wickets and two broken bails for 18 runs.

Team.—L. D. Carton-Kelly, A. E. Trist, I. A. H. Munro, J. D. Williams, W. H. Garland, H. M. C. O'Driscoll, P. S. Carton-Kelly, K. D Allenby, K. Little, R. A. Hancock.

GUY'S *v.* CHARING CROSS AND R.D.H.

Result: Guy's, 211; Charing Cross and R.D.H., 111 for nine.

Our opponents won the toss and gave us the opportunity of batting first on a damp wicket. The score was compiled at a moderate rate with the earlier batsmen all returning in their 'teens. With the score at 66 for five Sheerboom joined Harvard-Davis to put Guy's out of danger and bring the score to 154 before they were separated. Both scored fast, driving fluently to off and on alike, despatching anything loose, and exploiting to the full opposition's fielding. Pritchard completed the picture with a brisk 25, and Guy's, reaching 200 for the first time this season, were all out for 211.

When the Charing Cross and Royal Dental batted Salkeld demonstrated his liking for the half-volley, no matter who bowled it, and soon he had scored 29 before being caught by Trist off O'Driscoll, and it was he who, with Swale making a slower 24, brought the score to 82 for four.

At this stage with none of our bowlers getting concrete results and with only forty minutes of play left, Harvard-Davis was summoned and instantly eradicated two men in his first over and one each in his second and his third.

It was due to him and possibly, to Carton-Kelly at the other end, that nine wickets

were down at the close; time alone robbed us of victory, the opposition being 100 runs behind and with only one wicket in hand.

Team.—L. D. Carton-Kelly, A. E. Trist, I. A. H. Munro, D. J. Sheerboom, J. D. Williams, W. B. Webb, K. G. B. Pritchard, F. R. Lambert, R. Harvard-Davis, H. M. C. O'Driscoll, W. H. Garland.

GUY'S *v.* PUBLIC SCHOOL WANDERERS.

(*Played at H.O.P. on Saturday, September 1st.*)

Result: Draw. Scores: Guy's, 185 for 2 (declared); Public School Wanderers, 64 for nine. (Rain stopped play.)

Rain seemed inevitable at some stage of the afternoon and Guy's considered themselves lucky to win the toss. Going in to bat, their first wicket fell at 10. It was then that Munro and Williams came together, and there they stayed, both batting confidently, and scoring all round the wicket. The partnership had reached exactly 150 when Munro was caught for 74, after he had begun hitting at everything. Munro had batted well indeed, his many scoring shots being good to watch. If only his defensive back play yielded one run instead of the ball dropping at his feet, then the 74 might easily have been a 100. Munro left at 4.50 p.m. At 5 p.m. Guy's declared; Graham, joining Williams, had hit 14, including a six and a four, raising the total to 185 for two wickets, while Williams was undefeated with 66. His style was copybook and pleasing to see. He, like Munro, is at home with anything the bowler chooses to bowl. With more perfect timing of his drives he, too, could have reached his century. Both Munro and Williams are to be congratulated on such a very fine display of batting.

The Wanderers, going in to bat, appeared as unhappy as the weather. The bowlers must have looked much more than 22 yards away in the fading light. Except for a bright spell of hitting by Salkeld (26), Webb kept the batsmen continually ill at ease. His analysis being four for 26. Graham in three overs removed two batsmen for 4 runs. Finally, the rain came with eight wickets having fallen. On its cessation there was time for but two further overs. The close of play saw the Public School Wanderers still in the field with 64 runs for nine wickets.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, J. D. Williams, D. J. Sheerboom, W. B. Webb, I. A. H. Munro, K. G. B. Pritchard, F. R. Lambert, W. H. Garland, W. A. Evans, R. Harvard-Davis.

House Officers—Sector 10

AUGUST 1st TO OCTOBER 31st, 1945

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S. Batty Shaw, A. Pentney, B.H.(B.2). May, P. R. A. (B.2) Thomas, J. M. (B.2)	Thorne, M. G. Kinder, C. H. Huntley, A. M.	Macrae-Gibson, N. K. (B.2) from Wildernesse	Reinhold, J. D. L. to Orpington	Irvine, R. E. (to B.1). Trounce, D. Q. Thompson, R. C. W.
WILDERNESSE. Woodside, R. M.	Fox, W. (B.2)		Macrae-Gibson, N. K. (B.2) to Guy's	
JOYCE GREEN. Vidot, C. C.	Morse, A. V. (B.2) from Aug. 10, '45			Lloyd, D. O. Gibbs, A. E. (7.8.45).
ORPINGTON. Van Diggelen, H. (B.2) Cashmore, A. A.	Green, R. A. Barclay, R. F. (B.2), 1.9.45	Reinhold, J. D. L., from Guy's		Williams, O.H.E. (to B.1). Wheatley, D. P. Nicholson, N. G. (student)
FARNBOROUGH. Haas, G. J. (B.2) Nicholson, D.P.(B.2)	The, I. T.			Brittain, R. G. L.
PEMBURY. Macdonald, I. (B.2) Watford, N. C. J.	Pearson, P. F. (B.2) Wallace, J. D.			Murphy, E. G. Dixon, A. St. J.
SOUTHERN. Ebsworth, J. S. (B.2) Bensted, J. P. M. Davies, D.	Breeze, D. G.			Leeson, P. C.

Hospital Information, etc.

Notices

Applications are invited from qualified medical practitioners for the post of Resident Medical Officer to Nuffield House. This post is graded B 2, and carries a salary at the rate of £250 per annum with full residential emoluments. The appointment will be for a period of six months in the first instance, but this will be extended for a suitable applicant.

Applications should be sent to the Secretary of Nuffield House, Counting House, Guy's Hospital, S.E.1, not later than October 12th, 1945, and the selected applicant will be expected to take up his duties between January 1st and 14th, 1946.

DENTAL SOCIETY ANNUAL DANCE.

The annual dance of the Guy's Hospital Dental Society will be held at Grosvenor House, Park Lane, on Thursday, November 8th, from 8 p.m.–1 a.m. The cost of tickets is 14s. each.

As circumstances with regard to food have now eased, a light buffet will be included in the price of the ticket. Extensive bar facilities will be available.

The numbers will have to be limited; therefore those who wish to be present should apply as soon as possible.

All members of the Hospital will be welcome.

A. E. TRIST,
L. D. CARTON-KELLY,
Hon. Dance Secretaries.

Change of Address

P. D. Bryant, F/O., R.A.F., No. 9 R.A.F., General Hospital, A.F.S.E.A.

Patrick Clarkson, Major, R.A.M.C., c/o British Army Staff, Washington, U.S.A.

C. E. Gallagher, O.B.E., M.R.C.S., 196, Main Road, Sidcup.

A. M. McCall, Surg.-Lt., R.N.V.R., R.N.A.S., Abbotsinch, Paisley, Scotland.

J. N. Martin, M.R.C.S., 1, Sudbury Hill, Harrow, Mddlx. (Tel.: Byron 2214.)

L. J. Moir, Major, A.D. Corps, No. 51 Field Dental Lab., B.A.O.R.

N. S. Plummer, Brigadier, R.A.M.C., Medical Directorate, G.H.Q., M.E.F. (Home), 14, St. Simons' Avenue, Putney, S.W.15.

R. Ernest Rix, M.R.C.S., L.D.S., 35, Harley Street, W.1. (Tel.: Langham 2211.)

P. F. Stebbing, Lt., 3rd Madras Regiment, 47th, Indian Bde., O.T.W., India Command.

W. G. Tillman, Major, R.A.M.C., B.M.H., Poona, India Command.

C. V. L. Williams, L.D.S., 30, Brighton Road, Sutton, Surrey.

The Services

AWARDS.

Mentioned in Dispatches.

For gallant and distinguished services in Italy:—

Lt.-Col. (Temp.) R. T. Grant, R.A.M.C.
Major (Temp.) R. A. R. Topping, R.A.M.C.
Capt. (Temp.) J. A. J. Hammond, R.A.M.C.

For gallant and distinguished services in Burma:—

Major (Temp.) F. I. Evans, R.A.M.C.
Major (Temp.) G. W. Pinder, R.A.M.C.
Capt. J. W. Doupé, R.A.M.C.
Capt. J. C. Henry, R.A.M.C.
Capt. A. C. Greene, I.A.M.C.

Lt.-Col. W. G. Bradbeer, A.D. Corps, in recognition of gallant and distinguished services in Italy.

Captain J. R. Andy, East African A.M.C.

The undermentioned in recognition of gallant and distinguished services in North-West Europe:—

Lieut.-Col. R. Evans, R.A.M.C., Captain C. N. Mills, R.A.M.C.

Births

CRIPPS.—On August 22nd, 1945, at the Middlesex Hospital, to Margot, wife of Norman Cripps, Captain, A.D. Corps, S.E.A.C.—a son (Stuart Norman).

CROSS.—On August 15th, 1945, at Braunton Nursing Home, Devon, to Mary, wife of W. George Cross, Ft.-Lt., R.A.F.V.R.—a daughter.

ECKSTEIN.—On August 19th, 1945, at Guy's Hospital, to Jeanne Claudia (née Lucy), wife of Igor Eckstein—a daughter (Veronica Ruth).

ELLERKER.—On July 16th, 1945, in Guy's Hospital, to Veronica (née Morris), wife of A. G. Ellerker, Surg.-Lt., R.N.V.R.—a son (Anthony Robert).

WALTERS.—On August 21st, 1945, at Guy's Hospital, London, to Noëlle (née Paré), wife of Ian Walters—a son (Michael John).

WETHERALL.—On July 21st, 1945, at the Military Hospital, Wellington, South India, to Ruth (née Caldwell), wife of R. G. Wetherall, Captain, R.A.—a daughter.

Marriages

MOYERS—BRIGGS.—On July 17th, 1945, at Habbaniya, H. W. Moyers, Captain, R.A.F. Levies, to Margaret Briggs, P.M.R.A.F.N.S.

OUTRED—MOSS.—On July 28th, 1945, at Wilmslow, Charles Francis Outred, Captain, R.A.M.C., to Margaret Jean Moss, V.A.D.

Deaths

BIDDLE.—On August 21st, 1945, as a result of a motor accident, Eric Biddle, M.C. and bar, M.B., B.S.(Lond.), of 23, Henley Road, Ipswich.

CANE.—On August 29th, 1945, at Easterbrooke, Tilehurst Road, Reading, Lionel Charles William Cane, M.R.C.S., L.R.C.P., late Captain, R.A.M.C., and M.O., Park Hospital, Reading.

CARRELL.—On August 28th, 1945, suddenly, at Kingswood, Surrey, Dr. George Northen Piccaver Carrell, aged eighty-nine.

CARRUTHERS.—On August 1st, 1945, in 21st General Hospital, India, as result of wounds, Austin Stuart (Joe), Lieut., R.A.M.C., beloved husband of Mollie (née Lancaster) and father of Richard and Susan, 8, St. Albans Road, Norwich.

GREENE.—On August 17th, 1945, suddenly, in India, of infantile paralysis, Major A. C. (John) Greene, I.M.S.

POOLE.—On August 14th, 1945, in Victoria Hospital, Worksop, Stuart Kingsley Poole, L.M.S.S.A., Scarcliffe House, Langwith, Mansfield.

REEVES.—On August 28th, 1945, at 66, Upper Tulse Hill, S.W.2, John Kingham Reeves, B.A.(Oxon), M.R.C.S., L.R.C.P., aged eighty-five.

SALTER.—On August 24th, 1945, Alfred Salter, M.P., M.D., 5, Storkes Road, Bermondsey, S.E.16.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1492 *29th September, 1945* *Ninepence*

PASSIM

CUSTOM has wisely ordained this, the October edition of the *Gazette*, to be a special introduction for newcomers to life at Guy's. For the last three years this welcome has been confined to descriptions of the various branches of teaching: medical, dental, nursing and the like, that have, it is true, been the prime object of the entry of the new student to the Hospital. Moreover, the *omnibus* report of all the activities of the Clubs' Union which have accompanied these descriptions could do no more than hint that it was of a broader education that new Guy's men were invited to partake, than a mere course of medical instruction. Lack of editorial space was responsible for this inadequacy of information; but now we can print some at least of the separate reports on the individual clubs and societies that make up the Union.

Custom too it was, that used to prompt the writer of this page to preface his remarks with an invitation to the new reader to scrutinise that which was written within, and with an apologia to the old lest he found the contents repetitive and therefore unreadable. This year however, invitation and apologia are both addressed to the new reader, for the excavation of an old tradition has disclosed, amid the stagnant humus of three years of disuse, the presence of a number of corpses. What, for example, can we tell the newcomer about Guy's Hospital Debating Society, which in 1937 was holding six well-attended meetings a year? Our comment for 1945 must be: "This society is virtually defunct." Who now, of our readers has heard tell of the Musical and Operatic Society? This body which consisted once of choir, orchestra and soloists, giving frequent recitals, is now mutely inanimate. Shall we turn now to yet another corpse, the Students' Physical Society? Perhaps it is the illusory glimmer of life that appears at times to emanate from it that attracts the eye. Whether indeed it exists or not it has, like Dickens' Chancery prisoner, grown so like death in life that we know not when it dies. This now, had been a most robust and worthy institution, which, to quote he who introduced it to the newcomers of 1938, "aimed at presenting a series of meetings at which medicine is studied in its widest aspect as an art rather than a science, and in an atmosphere far removed from the examination room, where it can be enjoyed to the full." Its present pallid existence serves only to impede the more vigorous rebirth of this society, its ghostly form should be exorcised. Having completed our tour round this cemetery of Guy's social activity we must await the therapeutic exhibition, at all levels of hospital society, of some elixir of life.

Scrupulous in our care to start a new paragraph, we would however, urge the use of a few drops of such a medicine to coax from our readers contributions for this magazine. Paper shortage, apt camouflage for literary inertia, cannot last for ever and an increased number of pages in the *Gazette* must not be accompanied by increasing difficulty in filling them. There is room for writings from every type of pen—for poetry, prose, for modern verse even. Sketches too, in pen or pencil or photograph, humorous or serious in mood, would all be welcomed. The most valued contribution of all however, the clinical article, is one that any student who chose to write up an interesting ward case could well make; and it is the student, *par excellence*, who has opportunity to do this. Concerning "Correspondence" it can only be said that there have been occasions in the past when the writers of this page—and, indeed, the authors of certain articles in the *Gazette*—have "got away with" the most erroneous and doubtful statements without any protest whatsoever from readers. These escapes are probably not due to lack of the reader's perception, but to sheer want of interest. Let our pages then, be well flavoured with the spice of comment and the salt of criticism. We have free speech in this Hospital—or, at any rate, a liberal censor.

READERS will be interested to hear that two of the wards of the old Surgical Block, Lydia and Queen, have now been re-opened. These wards will house only post-operative and recuperating patients until the Old Theatres have been fully repaired.

IN response to many requests Dr. Bishop's two articles, "Guy's in the 'Blitz'" and "Guy's and the German War" have been reprinted in the form of a single booklet entitled "The War and Guy's, 1939–1945," which may be obtained at the *Gazette* office.

THE *Gazette* hopes to publish a list of Guy's freshmen in its next edition.

Psychological Medicine and the Family Doctor

A Lecture delivered at Guy's Hospital by R. D. GILLESPIE, M.D., F.R.C.P., D.P.M., Physician for Psychological Medicine, Guy's Hospital.

(*Concluded*)

TYPES OF PSYCHOGENESIS.

It is worth while pointing out, what has not usually been said, that in the psychological approach to patients the family doctor has advantages not possessed by any specialist or consultant. The reason for this becomes clearer when we remember that the main causes of psychological ill-health can be classified as—(*a*) constitutional, (*b*) situational (to use an ugly but self-explanatory word), and (*c*) historical, in the sense of something dependent on events far back in the patient's life. It is especially in (*a*) and (*b*) that the family doctor possesses advantages. In connection with both, it is necessary to remember that there is no apparatus or technique which will make even the most able specialist always certain when the patient is telling the truth or is concealing it, and so he has to depend for some of his information on outside sources, which are often not nearly so accessible to him as they are to the family doctor. Again, many psychological problems are closely related to the character and temperament of the patient, and there is no satisfactory laboratory or consulting-room test of character and temperament, although some things are helpful. Nothing that we have at present surpasses or even as a rule equals in reliability the knowledge of the day-to-day behaviour of an individual such as is accessible to those who are in contact with him in his, so to speak, natural surroundings. In contrast with the consulting-room—which represents a special and artificial environment in which it is very easy (in fact, almost inevitable for the patient, at any rate in his first interview) to display a façade that is extremely artificial—the family doctor is much more likely to be in a position to know when the patient is being truthful and to learn something about his temperament, not only from contact with the man himself, but also from his relatives and possibly some of his friends.

These considerations have a very important bearing on the evaluation of the various types of causal factor, whether constitutional, situational or historical. The assessment of the constitutional factor, for example, depends very much on a knowledge of the family history. A family whose child I was treating concealed from me for a whole year the fact that an uncle had died insane and that the brother was a "near-miss" to schizophrenia. The family doctor had sent this case to me by post, as it were, and I had not had an opportunity of talking with him. It is astounding with what aplomb people will say there is no mental illness in their family. One realises this especially when, from some other quarter not known to either patient or relatives, one happens to hear that there is. Contrast this position with the possibilities of the family doctor, especially if he has lived in the same district a considerable time and knows the people. Sir Thomas Clouston made an inquiry into the family history of eighty-three families taken at random in a country parish in Scotland, all the members of which were personally known to him for three generations.

He said: "I took every family I really knew, and no others. I made no selection. They were all country people—decent folks, hard-working, thrifty, few very poor, indeed mostly money-loving, with scarcely any drunkards. . . . I took advantage of my intimate knowledge of the people as a doctor to count the lesser attacks of melancholia, the milder delusional states, and the milder degrees of imbecility that would not have gone into any public statistics of lunacy or census schedules. Still, they were all mental diseases or defects just as truly, from the scientific point of view, as our acutest case in Morningside" (the Royal Edinburgh Mental Hospital). "The result was this —that, of those eighty-three families, I knew that in forty-one of them one or other of these four diseases had occurred."

His remarks refer, of course, only to more or less strictly mental diseases; but the same is just as true, and even more important because they are in greater number, of the conditions that we now know as psychoneurotic and psychopathic. There has been a tendency on the part of over-enthusiastic psychotherapists to neglect, and not to trouble to evaluate, the constitutional factor in the patients whom they undertake to treat. There is a fair amount of evidence that such disorders as phobias, which are often supposed to be entirely determined by complexes, are far more often apt to arise in those whose ancestry shows some neurotic stigmata as well.

I am thinking, for example, of a patient of mine who has a phobia of open spaces which prevents him from going far from his home, and whose father had a similar phobia; and of another patient with a such-like difficulty whose father was eccentric and extremely reluctant to meet anyone outside his immediate family. Another patient occurs to me who had a great deal of neurotic anxiety, whose mother had epilepsy, and whose uncle was insane. Instances of that sort are frequent enough to make the conclusion extremely probable that there is more often a constitutional factor in the psychoneurotic form of illness than has been admitted in the sometimes rather undiscriminating enthusiasm for psychotherapy. Dr. Felix Brown's researches on the familial incidence of psychoneurosis support this view.

A knowledge of these things, which certainly comes more readily to the family doctor, is of value in prognosis. It is of course desirable that the family doctor should reside for a considerable time in the same district. The rolling stone in medical practice will certainly gather very little of this essential knowledge. One of the best letters I have ever had about a patient came from an old practitioner in the North of England who said that he had known the young woman whom I was to see since she was a baby, and had known her mother since she was a baby, and had also known the patient's grandmother. Such a long perspective is, of course, very rare, and I often think that the death of an old doctor is in this respect a much greater loss to the community he serves than we are apt to think. It is particularly in the psychological aspect of medicine that the life-history is important. The specialist envies the family doctor his opportunities in this regard. The value of a life-history obtained from direct observation from childhood into adult life is so great that it has always been my ambition to collect case records of the difficult or nervous children referred to us at Guy's, so that we could get in touch with them in their adult life. Healy has recently done this in America, but no psychiatrist has a similar opportunity here; and even with the best arrangements in the world it would be very difficult for the specialist to keep track for any length of time. For the general practitioner in not too urban a district the chances are very much better and his data potentially much more reliable. Healy and his associates took the opportunity of correlating their patients' childhood as they knew it with the history given retrospectively afterwards, and found striking differences, partly as a result, no doubt, of the falsification by the rosy mists of memory, or, more technically speaking, by the workings of selective repression.

"SITUATIONAL" FACTORS.

With regard to situational factors, as distinct from constitutional and historical ones, the family doctor has a special part to play and special opportunities for playing it. In fact, his opportunities of collecting data from the patients' immediate circumstances and from the patients' life-history put him in a unique position as a kind of social pathologist. It seems to me that this may even be one of his chief roles in the future, which no one can take from him. One often hears that he is losing portions of his work to his clinic and to that organisation, and so forth, but the fact that he lives among the people whom he serves, and especially knows something of their family life,

means that he can fulfil a function that no one else will be in position to do. I cannot see the English public admitting social workers to their homes on the same terms as the family doctor—not, at any rate, if the latter lives up to his best tradition and reputation.

Moynihan used to contrast the pathology of the dead-house, or morbid anatomy, with the pathology of the living. Psychological medicine is really the pathology of life or social pathology. This pathology concerns itself with the jealousies, disappointments, annoyances, grievances, dissatisfactions, fears, anxieties, and so on that produce the aches and pains that we call frictional. The lumbar pain without discoverable basis which the gardener had yesterday, and which disabled him for the time being, can be traced to some annoyance at his master's attitude. The headaches that the dutiful daughter complains of may arise, if she did but know it, from a smouldering resentment at her invalid mother, whose invalidism in turn may be just a method of keeping her daughter at home; while Mrs. Jones's asthma may be nothing but an expression of her aversion to her husband.

The specialist confronted with functional symptoms due to situations of this kind has to start from scratch, and is very much at the mercy of what the patients care to tell him. I have known patients conceal for months facts about themselves which were fundamental and not at all unconscious, and this not only from myself, who am perhaps simple-minded, but from my colleagues. The family doctor, on the other hand, may know these things already. The fundamental truth implied in the term "situational" is that emotional situations generated by unsatisfactory circumstances and disappointing relations with other people cause emotional tension that generates symptoms—mental or *prima facie* physical—which are the complaints the patient brings to the doctor. The simplest situation is where the job is suitable.

For example, a young woman, a telephone operator, complained of attacks of faintness and giddiness which occurred at her work. Physically she was perfectly sound; intellectually she was considerably above the average and had won a scholarship at school; but on leaving she had to take a post which would quickly bring remuneration, as her father was dead and her mother was largely dependent on what the daughter could earn. Her desire to become a schoolmistress was thus frustrated, and she became a telephone operator. The technique, such as it is, was easily mastered. This done, the work merely became monotonous, giving her ample time to ruminate over her frustrated career and later (in the sequence that is common) on her health. The usual hypochondriacal consequences ensued.

Again, there was the case of an elderly man, the father of a large family, who had suffered from headaches for thirty years—headaches which left him during his holidays. He was an intelligent man, who had worked on the same routine job, long since learnt by heart, for forty years. For most of that time he had been heartily sick of the work, but he had hoped for promotion. At length it became obvious that he could justify hope no longer, and then the headaches which had already begun become permanently installed. Here, too, was a neurosis resulting from occupational misfit and monotony; but again there were other factors—in this case the disappointment of legitimate ambition.

The same situation may of course be pathogenic for one patient and not for another, and this is where knowledge of the character and temperament of the individual will be of the greatest service. The group of disorders is also one which the family doctor is fairly often in a good position to assess and even to treat: first, by explaining to the patient how symptoms are related to emotional tension; then, from his knowledge of the circumstances, advising whether the situation can be altered, as by change of job, or whether it must be faced; and, if necessary, not forgetting to point out where a fault of outlook or a defect of character has been mainly responsible for the failure of the patient to solve the difficulty on his own.

The usual objection made by the family doctor to the psychological side of medicine is his lack of time. The late T. A. Ross, who was himself in general practice for twenty years, used to reply that the proper use of time was necessary, and that an interest in psychological medicine would save the doctor's time in the long run. Another objection that may be urged is this: How can the general practitioner be expected to know the circumstances, dispositions and temperaments of, say, 2,000 possible patients?

But psychological disorders are very often related to family affairs, and although the general practitioner may have a clientele of 1,000 or 2,000, it is probable that the total number of family groups involved is considerably less than this, and the more neurotic families will probably consult him a good deal oftener than the rest.

"COMPLEX" FACTORS.

The third large group of psychological disorders consists of those in which neither circumstances nor situational factors are important, and the symptoms of which are a legacy of some far-distant miscarriage of psychological development. This, on the therapeutic side, is the specialist's domain, since the discovery of the pathological processes and their rectification require a special technique of explanation and many hours of painstaking work. But even here the family doctor can give useful hints from his knowledge of the patient's life-history. Many of the complex-determined psychoneuroses originate in childhood or even in infancy. One of the most potent causes is emotional insecurity on account of insufficient parental love, or, as it is usually called, "parental rejection." Few people are in a better position than the family doctor to know whether a child has been wanted or not, and this knowledge may be a key to all that goes on subsequently. In fact, in the field of child psychiatry itself the family doctor has opportunities which the specialist might well envy, since he is often present in the early days of life and sees the mother's attitude, and whether there is over-protection or rejection, or both, these attitudes being so often determining factors in the subsequent behaviour of the difficult or the neurotic child.

Views on the deeper pathology of neuroses have been drifting away from exclusive preoccupation with the Oedipus complex—a development which might well be beyond anyone's observation at the time—to a more comprehensive theory of the causation of neuroses. It will be seen that, although the type of psychoneurosis that is dependent on early faults of psychological development may probably always remain the particular field of the specialist, nevertheless the family doctor can collaborate with him in providing bits of information that may give valuable hints on the nature of the early causes.

SEXUAL FACTORS.

There is one type of situational problem which I have left for separate mention until now, and that is the sexual. In calling it situational I am of course not forgetting that its roots may extend far into the individual's past. It has long struck me as peculiar that practically no medical school in the country offers a course in sexual psychopathology to its students. I suppose it means that the parental attitude of the medical schools parallels the attitude of most parents in this country, in that it prefers to leave the young to find out for themselves. This is not a satisfactory position for a doctor, who as soon as he has qualified is regarded by the lay public as a repository of mysterious knowledge in this respect. It seems only fair to the doctor, and also to the public, that he should be provided with a modicum of information on the nature and cure of the most common group of maladies about which he is likely to be consulted.

The most frequent inquiries concern impotence, frigidity, masturbation and homosexuality. It has been well said of impotence by Dr. Ernest Jones that it is either very easy or very difficult to cure, and there is every reason to suppose that many such cases can be, and probably many of them are, cured by a doctor who understands that their commonest causes are ignorance, fear and misinterpretation of some previous experience. The deeper causes, often to be sought out only by the professed psychopathologist, are chiefly guilt-feelings and over-attachment to the mother. Similar factors, *mutatis mutandis*, are at the basis of frigidity. Homosexuality occasionally yields to superficial exploration and persuasion, but is more often a job for the specialist, who succeeds in curing only a minority of such cases. Difficulties of this sort naturally have ramifications in problems of domestic harmony. This may be the guise in which the thing first presents itself to the doctor; the other way is in the form of psychoneurotic symptoms elsewhere in the body, aches and pains generally, all of which are sometimes the direct result of sexual inadequacy or sexual dissatisfaction. But I imagine that a large proportion of doctors are shy of knowing these things about their patients and the patients are shy of telling their doctors, because it takes time to get down to a topic of that sort, and you cannot possibly broach it to someone who has only a short time to give you. It is nevertheless not true that the majority of nervous

conditions, even in women, are the result of obvious sexual situations of this sort, but they do undoubtedly play a part in some of them.

PROGNOSIS.

The hysterical conditions, commonly so called—that is to say, the paralyses and sensory disturbances—can usually be cured fairly rapidly by persuasion, at any rate so far as the symptoms themselves are concerned; but, having done this, you may find in a number of cases that you are left with a state of psychoneurotic anxiety which replaces the headaches and what-not previously complained of.

It is my impression that one will only completely cure a hysteric if he has ceased to have a motive for his disability and merely wants to know how to recover without losing his self-respect. This accounts for some of the more dramatic cures of hysterical paralysis in the last war: few of these patients were expected to return to the front. Some, in peace-time conditions, you can cure even when the motive still exists, by showing them what that motive is. Other cases, more rare, depend on unconscious mental processes associated often with guilt-feelings such as only professional psychopathologists can hope to find and tackle.

As regards psychoneurotic anxiety states, some of which are called by the Freudians "anxiety hysteria," prognosis for the "situational" group is good as a rule; so also is the prognosis for those cases of this type which arise from faulty upbringing and the acquisition of wrong ideals, and so forth; but the cases that depend on historical factors in the unconscious await the advent of the skilled psychotherapist before much is likely to happen to them. In the two groups together the statistics in the Cassel Hospital collected by T. A. Ross showed a recovery or "much improved" rate of 76 per cent. The data from the various psycho-analytic clinics recently collected by Knight showed a combined recovery rate of "cured" and "much improved" of 61 per cent. in approximately the same groups.

The trouble in assessing these results is the lack of satisfactory control groups, and there is no doubt that in some conditions a certain proportion of these people tend to get well themselves in the course of time. Any satisfactory investigation would require to distinguish not only loss of symptoms but durability of cure and its other features, such as the change in the social qualities of the patient concerned and the improvement in his general adaptation to life. Among cases of the obsessional or obsessive-compulsive variety the data are conflicting; I have no doubt that there are some cases which without special treatment would not improve at all or would improve very little, but it has to be remembered that here also there is a spontaneous recovery rate. I find statistics of this sort very unsatisfactory and the individual case much more convincing. Statistics should also take into account the duration of a treated case compared with one untreated. I believe that with treatment many psychoneurotic illnesses are shortened; and this, in fact, it would be fair to say—that psychoneurotic conditions are among the most curable of the chronic illnesses the doctor is called upon to treat.

CONCLUSION.

There is an outstanding fact which should commend the practice of psychological medicine to the clinician—and the family doctor is first and foremost a clinician. It is this: that psychological medicine remains pre-eminently a field in which the clinical method, independent of the laboratory and the test-tube, is still the fundamental one. Even the most recondite psychiatric history—such as, for example, that which psychoanalysis involves—is essentially a clinical history of the patient. The history of the patient, which should be a history not only of his symptoms but of his life as an individual, is both a means of diagnosis and the foundation of treatment. For diagnosis, of course, one has to know as well the natural history of physical diseases, while to use the detailed history for the purpose of treatment requires a knowledge of the principles of psychological medicine. But these principles in what I have called the "situational," and even in many of the historically determined conditions, are simple and can be applied successfully by anyone who cares to give his attention consistently to this aspect of his practice.

(*Reprinted by kind permission of* BRITISH MEDICAL JOURNAL.

The Clinical Period

WITH the termination of hostilities it is hoped that during the next six months at least five hundred beds will become available for teaching purposes on the Guy's site.

The reconditioning of Guy's House (the old Surgical Block) is already under way, and all the undamaged wards, theatres, etc., are to be brought into use as soon as possible.

This is obviously only a temporary measure pending rebuilding, but as it is so uncertain when this may be started, the School will welcome the re-opening of as many beds as possible at Guy's. Members of the Clinical Teaching Staff are rapidly being returned from the Forces. We have already welcomed Lt.-Col. Frank Cook, Lt.-Col. Gibberd, Lt.-Col. Grant, Major-General Ogilvie, Wing-Commander Ellis, Brigadier Boland, Air Vice-Marshal Symonds and Air-Commodore Gillespie, and we have news that Brigadier Grant Massie, Lt.-Col. Hedley Atkins, Major Harris, Lt.-Col. McConnell, Major Rink are likely to be demobilised in the near future. Within the next few months therefore, there will be considerable reorganisation of the Clinical appointments, but at the moment they are carrying on as during the last year, namely :—

Preliminary Clinical Period—	
Surgical Ward Clerk	Guy's.
Medical Ward Clerk, first three months	Guy's.
Junior Dresser	Farnborough.
Medical Ward Clerk, second three months	Farnborough.
Free Period	Guy's.
Obstetric Dresser, first three months	Farnborough or Pembury.
Obstetric Dresser, second three months	Farnborough or Pembury.
Senior Dresser and Special Appointments, Out-patients, etc.	Guy's.

Due notice will be given as soon as any changes are contemplated.

To Those Entering the Clinical Period

BY DR. A. H. DOUTHWAITE.

YOU are now exchanging the routine of arduous pre-clinical studies, interspersed with generous holidays, for the enlivening experience of working for sick people. If you have chosen your career rightly you will never have to complain of monotony, but you will at all times be over-worked, and the nearer you approach qualification the shorter will be your periods of leisure. No matter what schemes may be devised to guarantee a living for the indolent, there will never be a place in this Hospital for the type of student who avoids all duties save those which alone help him to pass his final examination. If you aim at becoming competent doctors you must apply yourselves with enthusiasm to your tasks from the very first. In short, work as you have never worked before. Imagine always that you have sole responsibility for your cases. Picture to yourselves what ought to be done, and decide which of these investigations you are capable of doing unaided. Then, with the permission of your house-officer, do them. You will learn more in three months on these lines than you would in five years of formal lectures.

As to the planning of your studies, last-minute cramming for final examinations is of no use. The subject is too vast for anything other than gradual absorption, so it is well to follow some plan from the outset. The Preliminary Clinical Period prepares you thoroughly for the routine examination of patients, and thus prevents waste of time when you enter the wards. Beds and their human contents are allotted to you, and *therewith your share of responsibility.* The taking of the medical history is the most important step towards arriving at a diagnosis. This is primarily your job, and its value cannot be over-emphasized, though too often forgotten in a desire to search for physical signs of disease. The ability to sift the relevant facts from matter which

obscures can only come with experience. In the meantime, bear in mind the value of facts, as opposed to patients' interpretation of them, and of their presentation in a legible and, where possible, schematic form. When writing a report, do so with the thought that on its accuracy may depend the outcome of valuable research undertaken years later. Whenever possible, examine your patient before he is seen by the registrar, and commit yourself to a diagnosis. Progress of the disease, its outcome, treatment given, opinions expressed on diagnosis, should all be entered to make the records of lasting value. Write down your findings and conclusions. It is the only way to avoid that type of mental dishonesty which leads to brilliant differential diagnoses any one of which can be claimed as a personal success at a later date ! This dangerous habit once acquired is difficult to discard. It meets with but scant respect, however, from the relatives of the sick. Mistakes have a high educative value. They snatch one with a jerk from the danger of self-complacency.

Probably the best plan of study is to concentrate for the first three months on pathology. This entails, of course, frequent visits to the post-mortem room. Given this grounding, symptoms and signs become the natural expression of the disease and their memorising is unnecessary. The most valuable time of the day for the acquirement of practical knowledge is that which follows the afternoon round. It is then that the house physician performs lumbar punctures, collects blood, taps chests and so forth. These procedures should be watched and from time to time you will be given the opportunity of carrying them out yourself. It is now, also, that special signs referred to in the teaching round can be re-examined and thus fixed in the memory. It should be made a point of pride that within a fortnight you should be able to inspect the optic discs of any patient you may choose. Once the knack has been acquired, and it usually comes quite suddenly after several days of disappointment, it will never be lost. It takes many months to be certain of the normal as opposed to the diseased disc, yet recognition of early change may be of the utmost importance in determining a diagnosis and possibly even in saving a life.

The patients in your beds will confide in you possible more than in the house officers or staff. To them you are their doctor and from you they will try to get confirmation of their fears in respect of illness, or of suspicions in relation to earlier treatment. An immense amount of mischief is caused by the making of unguarded remarks which can be misconstrued. Their avoidance is doubly difficult in a teaching hospital, where a discussion on the problem is too often carried out within earshot of the patients. We all err unwittingly in this respect, and the importance of discretion needs reiterating. The fact that a patient can inspect his own report is deplorable and should be remedied.

Attend Out-patients' when you can. This is the only hospital activity which remotely approaches the conditions which obtain in general practice. The frequent absence of physical signs may be tedious, but precisely for this reason is the experience invaluable in forcing you to rely more and more upon history-making. It is an antidote to the poison of mechanised medicine, whose virulance increases with every new instrumental aid to diagnosis.

Insure your life and health, and join a society for protection against legal action as soon as you are qualified.

In moments of despondency remember that Medicine is the only profession which never provides two days alike, and in which boredom is a rarity.

To Those Entering the Surgical Wards

By Mr. W. H. OGILVIE.

GUY'S HOSPITAL rightly enjoys a world-wide reputation as a medical school, which for generations has sent into all parts of the world doctors armed with practical knowledge and with the willingness and ability to take responsibility which a practical training implies. There are two special advantages of the teaching here—the great wealth of material which passes through the wards and Out-patients' Department, and the responsibility which is given to every man from the very outset of his career. In each appointment he is not taught only, he is asked to carry out essential work for the Hospital and for his patients, and trusted to carry it out well.

It is on the surgical side of the Hospital that you who are now entering the wards will first encounter the practical side of the profession you have adopted as your life's work, and the human material with which that work is to be carried out. It is as well that it should be so, for here the issues are clearer. Later will come the study of prolonged and progressive disease, of those degenerations which follow upon misspent lives or have causes still unknown, of failures rich in scientific interest, but at present beyond your power to remedy. You will meet much that is depressing. But during your first three months in a surgical ward you will find yourself in one of the most cheerful places in the world, where hope is the keynote, and hard, active, useful work your daily occupation.

For you who have chosen aright, this time will stand out with ineffaceable clearness for the rest of your lives. What has gone before has not been without interest, but the interest was academic. It was like the months of preparation in lecture rooms, on parade grounds, on the beaches, that welded a miscellaneous array of men into that highly trained spearhead of liberation, the twenty-first Army group. The crossing of the Channel took them from make-believe to real war, and as dawn broke they saw before them the defences they had often scaled in replica and the puffs of German guns. The rehearsal was over, the curtain was up. And so, in a surgical appointment, you are suddenly in the midst of real life. You are confronted with accidents, sudden infections, grave calamities. In the main it may be said of the patients whom you will encounter, that they are healthy, normal, sane individuals, struck without warning by some sudden misfortune. You are present at this crisis in their lives, and it is in your power to help in fighting it. There is something to be done; and when it is done it is your privilege to see the rewards of victory—the quick recovery and the return of hope.

There is another advantage of starting your career on the surgical side. You are introduced to disease in a comparatively simple form, and the knowledge of anatomy and physiology which is fresh in your mind enables you to grasp a great deal of what you encounter without the need of lectures or text-books. Very much of surgery deals with local disease—that is to say, there is one faulty structure in an otherwise healthy body. Given a thorough knowledge of anatomy and pathology the teachings of surgery become self-evident. Surgical diagnosis is little more than the answering of two questions—what is the anatomical structure involved and what are the pathological processes that have caused the trouble? A man has thrust his arm through a window and a piece of glass has penetrated the forearm. The first question that faces you, "What structures would be encountered from without inwards if an incision were made in such a situation?" is one that you might reasonably be expected to answer in an anatomical paper. The second question, "Which of these structures has actually been divided?" means an investigation of the sensation of the different nerves, and the movements carried out by the muscles and tendons which lie in the path of the injury, and a search for pulsation in the arteries distal to the wound. The treatment is an exercise in anatomy and craftsmanship, very interesting, because the relations which have been memorised by force of will are now brought vividly before you under the bright light of the operating lamp. Your hardly-acquired knowledge makes you not only a sympathetic fellow-man, but one skilled to restore function and promise recovery to the patient.

During these three months you will work very hard, probably harder than you have ever done before, but it is all tremendous fun. Your primary duty to the Hospital is to keep a record of the cases under your care. This you will do as well as possible, both for your own sake and because on the accuracy and lucidity of your account will depend the value of the record in years to come should the same patient be readmitted or should a series of similar cases be investigated for statistical purposes. Besides clerking, however, you will be expected to help in every activity of the firm to which you are attached. This appointment is your great opportunity for making yourself proficient. You should familiarise yourself with the somewhat elaborate routine of modern asepsis. You should take every opportunity to watch your cases being dressed and to acquire the handicraft of dressing yourself, to follow a clean wound through all the stages of repair to healing by 'first intention," to learn the variations in healing brought about by the age and health of the patient, the type of incision, the part of the body in which it lies, to note the indications that all is not well, that a hæmatoma must be evacuated or a drain inserted. In the next appointment you will be a dresser yourself, and will be expected to know your work. It is the privilege of the beginner to ask questions, and this you should do in season and out of season. All knowledge

which you acquire will stand you in good stead as a dresser, and as a dresser you will have more work to do yourself and less opportunity to learn by watching that of others.

You will go to bed very tired, and you will find little time to read. Do not, therefore, make any attempt to work through a surgical text-book, but read up your own cases carefully. True surgical knowledge is part of your own self, and is based upon a memory of individual cases followed through and committed to memory. To be thus remembered each case must be a clear-cut picture; therefore begin at once to form the habit of definite decision. At this stage it is far better to be certain than to be right. To begin with, you will have but little knowledge, but with what knowledge you have examine each case, make a definite diagnosis, and decide what treatment you would adopt. Whether the outcome proves you right or wrong, you will remember it, and you will have learned something in the process. But if you allow yourself alternatives you may be tempted to the complacent reflection that one of them at least was right. Any man who could remember all his mistakes would be the wisest surgeon in England at the age of sixty.

Be interested in everything in your patients and your fellows; no less in the nursing which completes the cure than in the operation which initiates it. It is an old saying that the wise doctor treats the patient as well as the disease. Enter into human relationships with your patients. They will call you "Doctor" and will hang upon your words, and there is much you can do to make them well besides ministering to their surgical wants. In this side of your work alone you will learn much that will help you to success in after life. At Guy's we are particularly fortunate in our patients. There is no foreign quarter in the Borough, no shifting population. British dockers, navvies, carters, factory hands and their wives and children, come into our wards to be made well. They are fine people and proud of living round the best hospital in England. Their happiness and our good name are in your hands.

The Dental Curriculum

A YEAR ago, in welcoming the new dental students, I expressed the hope that before any length of time had elapsed, work and study would be carried out in pleasanter circumstances than had been the case for some years past. That time has now arrived, the bombs and rockets and the black-out are things of the past; it is devoutly hoped for ever. Nevertheless, many other war-time restrictions remain in force, and it is well to emphasise the fact that your continued studentship at the Hospital is still dependent upon periodical reports of satisfactory progress to the Ministry of Labour. It is obvious therefore, that for your own benefit, in more ways than one, you should study diligently and work hard; at the same time remembering to keep a proper balance between your work and recreation. Failure to maintain this balance means that your work will suffer either, firstly, by too much time being devoted to recreation; or, secondly, by too little time in the same direction causing you to become stale.

If you carry out these precepts then your progress should be in all ways satisfactory, but if at any time you feel that such is not the case, then seek the advice of your teachers, advice which will be willingly and freely given.

Remember that this Hospital is a great public institution that has stood in high repute for many generations. This reputation has been earned for the Hospital by all who have been or are associated with it. Not only are you able to play your part in this connection, but it is up to you as a member of this institution to do so. Space being limited it is unnecessary for me to talk to you here about your actual programme of studies. Information in this respect can at all times be obtained from the Dean or Sub-Dean or other officials at the Medical School Office.

It is fitting here perhaps for me to offer one or two words of advice which should be advantageous to you. There are in existence a number of Prize Examinations held yearly for which you may enter. Now the winning of such a prize is, of course, a valuable thing in itself, but of equal, if not of greater, value in the long run is the experience gained during such an examination. Therefore enter for these examinations apart from any consideration as to whether you have a chance of winning a prize.

Another point to which I would draw your attention bears on the manner in which you should acquire your knowledge. All the teaching in the world will not make more than an average individual of you. You must go out of your way to acquire that extra which makes the difference between the average and the excellent. No one can do this for you; it depends entirely on your own initiative. One more word of advice —cultivate your power of observation. Probably at no other place will you have a greater opportunity to do so. If your power of observation is keen, then, not only will you obtain extra knowledge by your observation, but you will be able to make better use of the teaching that is imparted to you.

The actual courses of study will be found in full detail in the Prospectus of the School, which, if you have not a copy already, may be obtained at the Medical School Office. All students should make themselves acquainted with the contents of the prospectus, for therein are to be found the regulations respecting students with which students should be familiar, and other useful information, the possession of which may save much time and trouble.

And so a hearty welcome and good luck!

To Those Entering the Nursing Profession

GREETINGS to you in the sphere you are entering—a sphere abounding in interest and demanding your enthusiasm and concentrated effort.

Most of your training period will be spent under the roof of your parent Hospital, but you will probably have opportunity of seeing another type of hospital when you work at Orpington.

From the daily Press and from friends in the profession you will know that the number of entries into the nursing schools in England and also the number of nurses becoming State-registered have shown marked increase during the last ten years, and yet, in most parts of the country, we hear the cry that more nurses are needed. During the war years the demands for nurses have been great, but now the fighting has ceased so many channels will be open to the nurse who is State-registered and, as more attention is paid to the preventive aspect of medicine in the health services of the country, the demand for the trained nurse will be even greater.

You will see reconstruction in hospital and nursing services during the next ten years; therefore learn all you can of your craft, as a student nurse, and be ready to take a share in the affairs of your profession. You will have heard of the Horder and Rushcliffe Committees; these two bodies interested in nursing problems have recommended many changes and some of the changes have yet to be implemented. The draft syllabus drawn up by the General Nursing Council for a comprehensive training for nurses is also now being discussed. The Nurses' Act of 1943 at the present time requires the enrolment and training in certain approved hospitals of so-called assistant nurses.

At Guy's we were pioneers in nursing education in this country in introducing a modified "block" system of training. The Education Committee of the Guy's Nursing School unanimously resolved, at their last meeting, to urge that the full "block" system should be introduced at Guy's as soon as possible. This resolution has already been brought before the Governors of the Hospital. Under this scheme, groups of nurses would be withdrawn from the wards at intervals during the first, second and third years for periods of theoretical and practical instruction; two periods of seven weeks and the last period of two weeks during the three years have been recommended. Instruction and some private study would then be possible under conditions similar to those enjoyed by students of other professions.

And now, one more aspect of your life. Matron, speaking recently to trained nurses in one of the Kent hospitals, told us of the greeting used by the Egyptian patients in Cairo when, during her morning round, she asked them how they were. The usual polite reply, translated, was: "All the better for the sound of your voice; all the better for your presence." If we are real nurses, the patients should still be able to say this of us wherever we are working or whatever the conditions.

Yours is the privilege of training in Guy's Hospital, and yours the opportunity of service in the period immediately following the war.

D. L. H.

Senior Training Corps

THE University of London Senior Training Corps, represented in Guy's by the Medical Company (No. 4 Coy. U.L.S.T.C.), commanded by Major J. Whillis, is open to students who already have Certificate "A" and who wish to proceed their Certificate "B" (Medical).

Training commences in the Winter Term and is spread over the year with a break before the Summer Examinations. Training is completed at the Annual Summer Camp, which lasts a fortnight, and at which the Certificate "B" Examinations are held. Attendance at camp is therefore compulsory.

Although it is the policy of the School to encourage men to join the S.T.C., especially if they have previous J.T.C. or other experience, men are taken in only on a volunteer basis and are only accepted providing that they show keenness, live within a reasonable distance of London for attending all parades, and reach the required standard of physical fitness at the medical examination.

Further information may be obtained in the Medical School Office.

Guy's Hospital Clubs' Union

OWING to the limitation of space it will not be possible in this special number of the *Gazette* to give as full a survey of the activities of the Clubs' Union as before the war. Nevertheless the changes brought about by war conditions demand that the present status of the Union be fully understood.

For upwards of fifty years the affairs of the various clubs and societies have been under the partial control of the Clubs' Union Council, a body consisting of staff and students in whom is vested the power to allocate material or financial aid to one or other club as is deemed fit. The amalgamation has the great advantage in that it simplifies the collection of subscriptions which before that time had been a complex, if not a hopeless, business. Nowadays one subscription only is levied and this carries with it membership of any or all the constituent institutions (as are listed below), a free copy of the *Guy's Hospital Gazette* and the full use of any of the Clubs' Union premises, in particular the athletic ground at Honor Oak Park.

A second advantage is that the central control of the funds allows a fair distribution to be made to each club, whether the membership be large or small, and ensures continuity of purpose when it might otherwise be endangered by lack of support such as is always liable to occur when the more active members become qualified and leave the Hospital. As a result the years have seen a gradual growth in the number of its constituent bodies and the exploits of Guy's men in the field of sport are justly renowned.

It will be seen that membership enables the student to broaden his outlook both in the athletic and educational worlds. For those interested in sport exceptional facilities are available for increasing their proficiency, whether in a friendly game or an organised match. Fixtures have, of necessity, been curtailed since all unnecessary travel has been cut out and many opponents have had to close down for the duration of the War. None the less, the various secretaries should be congratulated in overcoming these difficulties, for, by arranging inter-hospital matches and games with representative teams of the three Services, an entertaining list of fixtures has been assured.

The Physical and Dental Societies provide opportunities for students to air their views on medical or dental matters. At these meetings cases from the wards are shown, controversial opinions expressed and from time to time papers are read on subjects of general interest. The Physical Society has not functioned since the War and must resume its activities this winter. All members are strongly advised to support these societies both for the advancement of their knowledge and for the chance they offer of taking part in the discussions. The Debating Society gives similar opportunities; there is practically no restriction on the topic discussed and, though its activities have been rather quiet of late, it is hoped that it will blossom forth this winter. These societies usually meet in the evening and the lifting of the black-out should encourage good attendances.

One of the most important bodies of the Clubs' Union is the Students' Club. Its purpose is to provide ample accommodation for students in their moments of leisure and newspapers, periodicals and journals in so far as funds will allow. A large room in the Old Pathology Block has been converted into a reading-room and the necessary furniture provided. The original reading-room in the College was destroyed during the air-raids.

At Farnborough, rooms have been set aside in "Summerlands," and at Pembury a hut has been erected in the hospital grounds.

The new student, on obtaining membership of the Clubs' Union, is strongly recommended to watch the notice-boards in the Colonnade at Guy's, in "Summerlands," Farnborough and the students' hut at Pembury, where information regarding meetings and practice games will be posted.

For all the above advantages and many more not listed the annual subscription now stands at four guineas, payable in October of each year.

All students who wish to enter fully into the life of Guy's are earnestly advised to join.

Below is a list of secretaries now to hand. Apologies are made for any inadvertent omissions :—

AFFILIATED.

Association Football Club	H. R. C. RICHES
Athletic Club	R. LONG
Boxing Club	M. P. O'REILLY
Boat Club	——
Cricket Club	W. GRAHAM
Debating Society	——
Dental Society	P. G. SHINGLER
Fencing Club	R. H. LARSEN and N. L. PORTER
Golf Club	——
Hare and Hounds	A. J. BEALE
Hockey Club	C. M. M. JENKINS
Lawn Tennis Club	R. FREEMAN
Photographic Society	S. P. JOHNS
Physical Society	——
Rifle Association	P. B. SMITH
Rugby Football Club	R. D. WILLCOCK
Sailing Club	D. J. REID
Students' Club	S. H. WASS
Squash Club	P. S. CARTON-KELLY
Swimming Club	R. ILIFFE

UNAFFILIATED.

Christian Union	S. R. W. POWERS and J. R. BURT
Students' Union	T. B. BREWIN

F. R. KILPATRICK,

Hon. Secretary, Clubs' Union.

RUGBY FOOTBALL CLUB

IN this the 102nd season of the Guy's Hospital Rugby F.C. we extend a hearty welcome to all Rugby-playing freshmen, in the hope that they will use the grand facilities which the ground at Honor Oak Park provides as a relaxation from Hospital studies.

The tradition of the club is as great as that of any in the country, and it is only by having keen, strong, junior XVs—after all, the backbone of the game—that we can continue to provide such an attractive fixture-list and maintain the high standard of play and sportsmanship so well upheld in the past.

In this transition period from war to peace, Rugby at Guy's must be regarded more seriously than it has been of late. Not only must we be able to include in our fixture-list any club in the country, but we must be worthy of the tradition and example set by our forerunners.

Fixtures this season have been arranged for four XVs and, should numbers warrant it, another XV can be fielded. Any player, desirous of a game, who has been omitted from a team after two Saturdays, should contact either the team secretaries or Mr. R. D. Willcock.

Lastly, I appeal to all Guy's men to assist in making this 102nd season one of the best, either by playing whenever possible or by supporting the teams on all occasions.

Any newcomer seeking information regarding rugger, should see either Mr. Willcock, Mr. G. Winston in the Library, or myself.

I. H. HILLIAM.

ASSOCIATION F.C.

THE Association Football Club at Guy's was established in 1882. So great was the enthusiasm of the team that in 1883 Guy's initiated the institution of the United Hospitals' Association F.C., and subsequently, in 1885, became the first holders of the Inter-Hospitals Cup. From that date the Inter-Hospitals Cup Competition has been held on fifty occasions, Guy's being the winners nineteen times.

In order to uphold this fine record we shall need many new players in the coming season. It is absolutely imperative that a strong and enthusiastic 2nd XI should be organised, so as to provide a source of replacements for the many fine players that will be leaving the Hospital team this year.

Our fixtures this season promise to be some of the best in the history of the club. They include the University teams of Cambridge, Birmingham and Reading, as well as such strong Service teams as the Royal Marines (Chatham) and the R.N.E.C., Greenwich. In all some thirty-five matches have been arranged.

In conclusion, on behalf of our captain, M. J. L. Sykes, and myself, I should like to extend a hearty welcome to all new Soccer players entering the Medical and Dental Schools this October. H. R. C. RICHES, Hon. Sec.

CRICKET CLUB

IT will be seen from the Retrospect that Guy's 1945 cricket season was a definite success; the number of games played were a record for the club, and in winning 50 per cent. of these the team felt itself justified.

Next season we intend returning to a full peace-time fixture-list, with a larger number of games than has hitherto been attempted. There will be a full complement of Saturday games together with Sunday fixtures and mid-week matches. 2nd XI fixtures will be arranged in conjunction with the 1st XI, and if the demand suffices, a 3rd XI will also be put in the field.

The year 1946 is to see the resumption of the Hospital's cricket tour. From August 7th until August 18th fifteen Hospital players are to tour South Devon. Matches will be arranged for every day of the week, including one or two two-day games.

It was decided at a meeting of the United Hospitals' Cricket Club, on Friday, September 21st, 1946, to begin the Hospitals' Cricket Cup Competition again during the season 1946. Whole-day games are played and the competition is of a knock-out variety. In the first match Guy's have been drawn against King's College Hospital.

In order to carry through this large programme of cricket next season, the whole-hearted support of the Hospital's cricketers will be required. It is quite certain that all those aspiring to greatness with bat or ball will be given every chance to display their ability. E. W. G.

THE HOCKEY CLUB

THE activities of the club have been rather curtailed during war-time. Before the War we ran four XIs, but for the past five years only one XI has been fielded regularly every Saturday. A 2nd XI was started again two seasons ago.

Our results, however, during that time have been extremely good. We won both the Inter-Hospital Knock-out Tournament and Six-a-Sides in 1944. A large number of our players have represented United Hospitals and London University sides. Last season the 1st XI played eighteen matches, of which ten were won and eight lost. Three teams were entered for the Six-a-Sides, and we were only narrowly beaten in the final.

This season a full and attractive fixture-list has been arranged for two XIs, including games with R.N.E., Keyham, and Gravesend H.C., with whom we have not previously had fixtures. If the club is to attain its pre-war size more support will have to be forthcoming. New players will therefore be very welcome irrespective of their standard of play. All those interested should watch the notice-board in the Colonnade or get in touch with the officers for the coming season—namely, L. D. Carton-Kelly (captain) and C. M. M. Jenkins (hon. secretary). C. M. J.

SQUASH RACKETS CLUB

THE Squash Club provides perhaps the most convenient facilities of any of the constituent clubs. Two excellent courts built just before the War stand in the Hospital grounds, and they may be booked for any time of the day in a ledger kept in the lodge of Nuffield House. Hot showers and a changing-room are available and one shilling provides light for an hour.

In this branch of sport enthusiasm throughout the Hospital is commensurate with the quality of the facilities, but of the skill of most of the players this cannot be said. New players are urgently required and keen students are asked to put their names at the bottom of the "ladder" in the gallery of the courts and should make every effort to work their way up. The temporary removal of the names of students residing in Sector hospitals from this "ladder" coupled with a greater attention being paid by older members to "ladder" play, should enable us to select the best team for the matches of the coming season.

P. S. CARTON-KELLY, Captain.
L. D. CARTON-KELLY, Hon. Secretary.

Reports on others of the Hospital's Clubs and Societies will be included in the next issue of the Gazette.

Correspondence

POST OF CLINICAL ASSISTANT.

To the Editor of the GAZETTE.

SIR,—Your reference in "Passim" of September 15th, 1945, to the post of clinical assistant suggests that the appointment was dropped because of the war. This was not so; it was abolished a few years before the war on account of shortage of medical beds. The scarcity was brought about by the increase in the number of beds allocated to specialties. It was, therefore, thought that it was no longer justifiable to reserve an entire medical ward for the exclusive use of six clinicals. The appointment was abandoned with great regret. As a substitute for it the post of assistant house-physician was created. The title carried much more weight when seeking jobs outside Guy's, but in value it was a poor substitute for clinical.

Yours, etc.,

49, Harley Street, W.1. A. H. DOUTHWAITE.

IN REPLY TO "UNCLE HARRY."

To the Editor of the GAZETTE.

SIR,—I will answer "Uncle Harry's" last line first. Mr. Rudyard Kipling told that story in "The Village that Voted"—(a Diversity of Creatures)—which, I think, is the best he wrote, and to me is the finest short story I have met. But the Geoplanariccus who were there defeated were supporting an hypothesis that had been proved untrue for four hundred years, and to which we may be confident knowledge will never return. The hypothesis of the "herd in disease" is a new one. I do not know whence I got it. Certainly not from my own brain. I have never had an original thought; but I believe I can absorb a similar idea from time to time. That is the trouble with the old in mind; they cannot.

I have often noticed that when you put a new idea to the young they will throw back their heads and roar with full-throated laughter; but if you do the same to the old in mind they give a guffaw cut short by a cough. I believe that the former indicates a release in the mind that "likes a strange idea as little as the body likes a strange protein," and means the new idea has got in; whereas the guffaw is the conscious and conscientious reaction which "resists it with a similar energy." I have so often heard that guffaw that to-day I speak, not to the old in mind, but to the young; and so I was doing this time. Freed from the limitations of a specialism, I wanted to put to students in the lecture-room and in *their* paper the conception that we cannot explain infectious diseases merely upon the advent to the body of a specific organism; and I was trying to suggest that in the mind of man there is a part on which much emphasis has of late been laid. that may be a third factor in the pathology of some of them. I may be wrong; but if I am it will be as well that those that follow should have thought it over and excluded it. It is the purpose of education to lead out the minds of our students, not to stuff them.

And now to answer some of "Uncle Harry's" statements. I would distinguish between the "community" and "herd." The community is all of us, but in our mental make-up we are not all "herd." The solitary animal is also a part of all of us; to some it is nearly their whole being. In this I follow Mr. A. Smith. Next I am one of those "foolish" people who believe that if you are afraid of a disease you are more likely to catch it. I learnt that from Charters Symonds, who told the tale of the cholera epidemic in London and how there was one member of the staff—Aston Key—who went in terror of it, and was the only one that died from it. I firmly believe that the shepherd poet had hold of some eternal truths when he sang, "Whoso dwelleth under the defence of the Most High shall abide under the shadow of the Almighty," and was touching on a problem in pathology to which we do not yet know the answer when he urged that, "Thou shalt not be afraid for the pestilence that walketh in darkness, nor for the sickness that destroyeth in the noon-day."

With regard to the use of the word "epidemic." I employ it to describe what I have known—the recurring exacerbations of a disease natural to an area and its people, such as measles, whooping-cough, chicken-pox and scarlet-fever in London. I do not think that the word fits a new disease attacking people that have not known it before. Nor can I admit that "strict control by the authorities concerned" determines whether infective diseases become scourges. Those who went through 1918 know that this had nothing to do with the influenza pandemic; and the whole history of scarlet-fever since 1870 shows that isolation hospitals have done nothing to limit the spread of the disease though they may have resulted in an improved care of the patients and treatment of the disease. Nor has the registration of brothels and certification of prostitutes done anything anywhere to control venereal disease. It is the "sanitary intelligence of the community," not "the strict control by the authorities concerned" that matters. The efficient administrator must be the servant of an enlightened community, not the bully of the breed; in that way lies disaster. The future of public health lies with the prophets of self-discipline rather than with the arm of the law. I thank "Uncle Harry" for his reference and will look it up when I get home; for some efficient administrator high up in U.N.R.R.A. is sending home all those of us out "in the field" who are over sixty; so perhaps I shall see you, or you will hear me, once again soon.

Yours, etc.,

Belsen, September 13th, 1945. T. B. LAYTON,

Reviews

A Manual of Elementary Zoology. By L. A. BORRADAILE, Sc.D. London: Oxford University Press (Oxford Medical Publications). 1945. Pp. xiii+813. With 551 figures in the text. Eleventh edition. *Price 24s. net.*

"THE present-day entrant to our universities is inexact, illiterate and illogical." This statement, made recently in a report on "The Interrelationship of Biology-teaching in Schools and Universities," undoubtedly has its exceptions, but these are so few that they serve only to emphasise its appalling truth.

Quo vadis? It would be well if the young medical student would pause to ask himself this question in these disturbed times. Through no fault of his own his early education has profoundly suffered and it now rests largely with him, by hard reading, by minute attention to accuracy and detail, by the careful and intelligent sifting of the results he obtains in experiments; in short, by his own effort, to acquire even now that attitude of mind which is essential before he can profit by any teaching whatsoever.

Now, biology is a subject which, *par excellence*, offers the student a sound training in accurate observation and inductive reasoning. To a very large extent he must, by reason of the shoddiness and inaccuracy of so many of the current texts, rely on his own powers of observation and criticism if he is so much as to pass an examination in the subject, let alone profit by what he has learnt. Fortunately, "Borradaile," without doubt the most widely-known standard text-book of elementary zoology, is far from being shoddy or inaccurate, and is a book which always repays careful study. Perhaps one reason why it is not more widely used by medical students is because it is a text in zoology and students imagine that it does not treat of biology. This idea is false. The book is based on sound principles of biology, and a study of plant biology merely shows how universal those principles are.

"Borradaile" has now passed into its eleventh edition and, as stated in the Preface, "the principal alterations and additions concern the maturation of the gametes, the

functioning of nervous systems, the relation of excretory processes to the environment, the history of the vertebrata, the embryology of the chordata, and evolution."

On the credit side such topics as muscle-action, locomotion, enzymes, hormones, and water regulation, have been brought up to date; meiosis is well done; and the terminology of the arteries in the dogfish has at last been given meaning. In the section on vertebrate embryology the development of *Amphioxus* has been revised in the light of Conklin's researches. The classification of the fishes has been revised, and between the last chapter and the excellent index there are two appendices on practical work, the first of which gives sound advice to him who reads it.

Apart from minor errors—such as the obvious misprint in the third equation on page 10—the book is singularly free from inaccuracies. Because of this one, deplores all the more the imperfections that exist. The bad logic of the footnote on page 16, together with that on page 5, and the statement on page 27 that respiration is the "reverse" of photosynthesis, takes one's breath away! Again, it is hard to understand why meiosis has been specially favoured above mitosis in the matter of revision. Surely the ghost of the "spireme" has been laid this many a long year?

Lastly, many of the text-figures suffer from the small page size. It would be a tremendous improvement if the publishers could be persuaded to recast the whole book and produce it in a really generous size—say, crown 4to or, at least, medium 8vo. However, let not this "post-war planning" be a deterrent to the student who seeks to improve himself by means of the present edition. E. W. B.

Clinical Procedures and their Background. By AGNES PAVEY. Faber and Faber. *Price 8s. 6d.*

I HAVE had great pleasure in reading through Miss Pavey's new publication. I think this book fills a long-felt gap in any Nurse's Library, but more especially in hospital where clinical investigations are constantly being done. This book gives the nurse in simple words the reasons for various investigations in which she is expected to co-operate intelligently with the medical staff; so often a nurse does not grasp these reasons and, for an intelligent and interested nurse, this means that she cannot experience full satisfaction in her work.

The diagrams of positions and apparatus used are clear and well executed and should be of great practical value and much appreciated. M. S.

Sport

Cricket

GUY'S *v.* METROPOLITAN POLICE.

(*Played at H.O.P. on Sunday, September 2nd.*)

Result: Won. Scores: Guy's, 157 for eight wickets (declared); Metropolitan Police, 104.

The weather promised to be kind when Carton-Kelly, winning the toss, decided to bat. The batting honours were shared fairly evenly. Williams was unlucky to be caught off a rising ball for 3. Munro contributed 15 before he also was caught. Harvard-Davis (29) and Graham (21) added fifty runs quickly, and then Evans took over. Despite three personal injuries in his first over he "smited" 35 brisk runs. Garland raised the score 10. Pritchard (17) and Trist (10) were both not out when Guy's declared their innings closed with 157 for eight wickets—an excellent total against accurate bowling.

The Police put on 50 for the first wicket. Harvard-Davis then came on to bowl his slows, and catches went to various boundaries where they were all without exception held. The venturesome batsmen were thus removed. From the other end Carton-Kelly, bowling at his best, disposed of the remaining players, the Metropolitan Police being all out for 104 runs, the captain taking four wickets for 9 runs, Harvard-Davis, 4 wickets for 27 runs.

Team.—L. D. Carton-Kelly, E. W. Graham, A. E. Trist, D. J. Sheerboom, I. A. H. Munro, J. D. Williams, K. G. B. Pritchard, W. B. Webb, W. H. Garland, W. A. Evans, R. Harvard-Davis.

Hospital Information, etc.

Notices

BOAT CLUB CENTENARY BALL.

A ball will be held in the latter half of October to commemorate the centenary of the Hospital Boat Club. The services of a dance orchestra from the Central Band of the R.A.F. have been secured, and it is hoped that double tickets will be available at one guinea. Further particulars will be announced as soon as possible.

Pass List

UNIVERSITY OF LONDON.
SECOND EXAMINATION IN DENTAL SURGERY.—PART II.
July, 1945.

*B. M. Bilton	A. K. Parsonage
H. M. Hughes	A. Rooms
D. G. Jones	J. S. Rose
J. G. L. Knowles	P. G. Shingler
S. F. Lamb	

* Awarded a Mark of Distinction.

THIRD (B.D.S.) EXAMINATION IN DENTAL SURGERY.

July, 1945.

Honours.

J. B. Kirkwood.

Distinguished in Surgery, Dental Surgery, Operative Dental Surgery.

Pass.

R. A. C. Dove — A. J. Sampson
G. A. Morrant

Supplementary Pass List.

The following Student has passed in Group I:—

C. D. Baker.

SECOND EXAMINATION IN DENTAL SURGERY.—PART I.

July, 1945.

J. L. Attenborough — L. A. Rosen
S. P. Johns — P. H. Smith
A. Levy — W. J. Tulley
R. A. J. Mayhew

The following Students are credited with Anatomy and Physiology:—

R. McK. Carson — P. B. Morris
J. D. Derry — T. C. J. Price
J. B. Harris — A. A. Robinson
N. R. Howells — H. E. Dyer
J. H. Keeling

The following Student is credited with Prosthetic Dentistry including Metallurgy:—
A. W. Hilliam

SPECIAL SECOND EXAMINATION FOR MEDICAL DEGREES.

(*For Internal Students.*)

R. J. Aspinall — G. E. Haward
P. Chadwick — J. L. Herbert
K. M. Citron — A. L. Jeanes
D. W. Clark — J. E. H. Lahaise
M. P. M. Coupland — C. J. G. Menzies
J. R. Deacon — C. P. Mills
I. I. Eckstein — J. T. Owen
J. C. Farrow — H. H. Richards
J. Fine — P. T. C. Rowan
J. R. Greaves — A. H. R. Rowe
D. H. Griffiths — J. Vance
M. W. J. Grummitt — P. R. Wagner
M. H. Handoll — J. D. Williams
D. F. N. Harrison — F. R. H. Wrigley

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

July, 1945.

Surgery.—B. H. Pickard.

Pathology, Bacteriology and Forensic Medicine, —R. G. G. Jones, B. H. Pickard.

Medicine.—H. Freeman, R. C. Jennings, G. F. Penny.

Papers by Guy's Men

Fry, J. C. Two cases of abnormality in the lower incisor region. *Brit. Dent. J.*, 1945, **79**, 100.

Ogilvie, W. H. Education of a Surgeon. *Lancet*, 1945, i, 228.

Dick, R. C. S., and Another. Neurosurgery in the Eastern Theatre of War. *Lancet*, 1945, ii, 193.

Stott, H. A case of cutaneous anthrax treated with penicillin. *Brit. Med. J.*, 1945, ii, 120.

Channell, G. D., and others. The immersion foot syndrome. *Brit. J. Surg.*, 1945, **33**, 17.

Beales, P. H., and Another. Double intussusception following multiple polyposis of the small intestine. *Ibid.*, 94.

Graham-Bounalie, F. E. Diet and rheumatism. *Med. Pr. & Circ.*, 1945, **214**, 72.

Herbert, W. E., and Wass, S. H. Multilocular cyst in the upper jaw. *Brit. Dent. J.*, 1945, **79**, 67.

Bailey, E. R. Notes on dental treatment in an Army intake centre. *Ibid.*, 70.

Cross, W. G. A case of non-hæmolytic streptococcal stomatitis treated with penicillin. *Ibid.*, 72.

Reading, Philip. A report of two cases of petrositis, treated with Penicillin. *J. Laryng. Otol.*, 1944, **59**, 459.

Smith, R. E. Diet and the School Child. *Practitioner*, 1945, **155**, 144.

Shaw, Maurice, and Oliver, L. C. ? Aplastic anæmia treated by splenectomy. *Proc. Roy. Soc. Med.*, 1945, **38**, 479.

Havard, R. E., and Others. Renal syndrome of wide distribution induced possibly by renal anoxia. *Lancet*, 1945, ii, 293.

Mollison, W. M. Earache. *Clin. J.*, 1945, **74**, 169.

Smith, R. E. Measles, *Ibid.*, 174.

Change of Address

R. O. Barber, M.R.C.S., L.D.S., 46, Bradford Road, Brighouse. (Tel.: No. 324.)

G. T. Hankey, M.R.C.S., L.D.S., 79, Harley Street, W.1. (Tel.: Welbeck 7476.)

B. H. Taylor, Captain, A.D. Corps, 27th Field Dental Centre, M.E.F.

The Services

Death.

Major A. C. Greene, I.M.S., in India.

Wounded.

Captain L. G. J. Pitt-Payne, R.A.M.C.

Territorial Army Decoration.

Lt.-Col. G. T. Hankey has been awarded the Efficiency Decoration of the Territorial Army.

Births

BREAKSPEAR.—On April 22nd, 1945, at the Bassett Nursing Home, Coventry, to Betty (née Fisher), wife of Edgar Breakspear, L.D.S.—a daughter (Hilary Joan).

WAKEHAM.—On August 16th, 1945, at Farnborough, Kent, to Monica (née Cooper), wife of John Y. D. Wakeham—a daughter (Margaret).

Marriages

BARKWORTH—WRIGHT.—On September 15th, 1945, at Herne Hill, F. Basil S. Barkworth, M.B., B.S., to Beryl Nellie Wright, S.R.N.

Deaths

HOGARTH.—On September 15th, 1945, at 105, Lee Road, Blackgeath, S.E.3, Christopher Wherell Hogarth, M.R.C.S., L.R.C.P., aged eighty-one.

LEISER.—On September 14th, 1945, in Guy's Hospital, George Leiser, M.D.(Berlin), of 95, Chomley Gardens, N.W.6.

OZANNE.—On September 14th, at Harrogate, Ronald Cathcart Ozanne, M.A., B.M.(Oxon.), aged fifty-eight.

PLUNKETT.—On September 19th, 1945, in Guy's Hospital, Joseph O. K. Plunkett, Acting Clerk, Superintendent's Office.

SMART.—On August 29th, 1945, Herbert Douglas Smart, M.C., M.D., of 26, Snakes Lane, Woodford Green.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1493 *13th October, 1945* *Ninepence*

PASSIM

SPORTS fixtures between teams representing the London teaching hospitals have been in existence for so long that they can now be regarded virtually as institutions; and there is no one who would wish this to be otherwise. Activities performed in the spirit of competition always produce the best results, and there can be no doubt that inter-hospital sport has a very beneficial effect upon the tone of the hospitals.

Anxious, however, to retain our sense of proportion, we hasten to add that the primary object of the student at hospital is to learn as thoroughly as possible the job which he has chosen as his career. It would seem regrettable, therefore, that virtually the only contact between students of the different London hospitals is through the medium of sport. Why should not inter-hospital activity be academic in nature as well as sporting?

How many Guy's men ever heard that great authority on heart disease, the late Sir Thomas Lewis, teaching on his specialty? The writer did, but the opportunity was only afforded by a chance invitation to University College Hospital a few hours before the time of the round. How many students outside Guy's ever attended any of the "open" rounds given weekly by the late Sir Arthur Hurst? Very few; we make the reply with confidence.

No very complex system would be necessary to effect periodic visits by limited numbers of students from one teaching hospital to another. The purpose of such visits would be to enable them to hear, in person, experts on a variety of subjects, both at the bedside and in the lecture theatre. True it is that occasional visits are made by students to such hospitals as Great Ormond Street for this purpose. These are excellent indeed, but do not extend the theory far enough into practice. The scheme we visualise would be one embracing all the London teaching hospitals.

Lists of the lectures and open ward rounds to be given could be issued by each hospital and circulated for posting at the other hospitals. By this exchange system students could be advised in advance and could plan to attend those rounds or lectures which were convenient for them. Some control of numbers, clearly necessary, could be effected by some simple method such as limiting the number of signatures appended to each item of those intending to make the visit.

It should be made quite clear that we visualise such a scheme as being essentially one subsidiary to work at the "home" hospital, and that it should not be allowed in any way to interfere with a man's curriculum at his own medical school. We do feel, however, that such a scheme, with a little care and co-operation directed towards its organisation, could form an addition to hospital work that would be at once instructive and pleasant.

WE are very pleased to publish in this *Gazette* an article, "The Silent Revolution," Dr. Vertue's appreciation of the work of Dr. Cameron at Guy's.

READERS will be pleased to hear of the return to Guy's from the army of Brigadier Boland and Lieut.-Colonel Hedly Atkins.

THIS week the Front Surgery lost the good offices of yet another retainer of the Hospital, through the retirement of Mr. MacNab. Even if he was, to use his own words, "Just a newcomer to the Surgery," some of Mac's fourteen years of loyal and unruffled service as Front Surgery Porter will be remembered by many Guy's men past and present.

A Silent Revolution

By H. St. H. VERTUE.

NOW that Dr. Cameron has left us, a fitting occasion arises to describe the revolution that has occurred in the health of the child at Guy's during his time—a revolution mainly of his making.

Consider for a few moments this child in the past and in the present—in the pre-Cameronian and post-Cameronian eras, so to speak. Thirty years ago the sick children were dotted about the various wards in cots, where they were under the care of those who knew nothing whatever about them, where they kept the other patients awake with their ceaseless lamentations and caught any infection that happened to be going. It was generally thought desirable to put them into the charge of the clinicals, often enough a passport to a better world. I used particularly to notice that a comparatively stupid man got the best results: Nature then got an occasional look-in and pulled the infant through; but your clever fellow festooned with medals was almost invariably fatal. This was especially the case in that grisly procession from cot to coffin that went on without cessation through the terrible epidemics of summer diarrhœa. In winter it was not much better, for there was another procession of absolutely livid children dying of broncho-pneumonia. Only those afflicted with the most deadly illnesses could be admitted, and this fact partly accounted for the heavy mortality, besides the utter ignorance on the subject that then prevailed. All the other children were seen by the O.P.O., a functionary whose efforts might be compared with those of some well-intentioned butcher's boy who had set forth to remove the Gasserian ganglion by operation. It was possible to see over a hundred children in the Front Surgery in one day and to send them all home to take their chance, furnished with bottles of physic, generally either "Mist Ipecac. Co." or "Mist. Belladonnæ Co." according to the fancy of the moment, and some "Lin. Camph. Co." to rub on the chest; what we did for diarrhœa I have forgotten, but perhaps it was castor-oil. Of the management of the infant absolutely nothing was known. I remember being dumbfounded by a young mother who asked me how to wean her child, and being obliged to appeal to my attendant nurse, who, being Irish and quick-witted, managed to produce advice of some sort at a moment's notice.

From this realm of Chaos and Old Night the children of the Borough had to be rescued. The first step was to appoint a physician especially to deal with children, and this duty was assigned to Dr. Cameron. The physician's plan was to gather under his care the children both inside and outside the Hospital, and this meant the building of a children's ward somewhere and the inception of children's Out-patients. All this sounds very easy now when these good things have been in our possession long enough for us to take them for granted, but consider: other physicians, and I dare say members of the nursing staff, had to be won over to relinquish the care of sick children, which they regarded as theirs by immemorial custom; a new Out-patients had to be started (not so difficult perhaps); and most formidable of all, the Hospital had to be persuaded to build and fit out a children's ward, where no such thing had ever been before. Lastly, there was to be a department where the mothers of the poor could learn how to avert those calamitous diseases that were wreaking such havoc with their offspring. This was a piece of imagination worthy of note.

A children's ward came into existence soon after the first German War—not a bad building to look at, with a Grecian portico in front and something very like the Ecce Homo Arch in Jerusalem behind. It was the old Anatomy School renovated, and it stood where Nuffield House now is. Unfortunately there was no cross-ventilation; the heat in summer could be stifling, and once or twice little patients lost control of their temperatures. Also the portico faced North and got no sun; and when it was proposed to put some of the cots out on the grass below for sunshine and fresh air, there were objections at first from the authorities. And, of course, the ward was not big enough. The second ward, that replaced the first, opened not long before the Second German War on the site of the old Bright at the top of Hunt's House, must have fulfilled many of the wishes of its begetter; though whether the absence of any green sward for the children was quite according to his desires, I cannot say. At any rate, "Diplock," as it is called, is something like a worthy reward for twenty-five years of effort. We are far indeed now from the cots in Mary and Esther, wedged in between the rheumatic fevers, the pneumonias, the heart-failures and the rest; farther still

from the " clinical," pumping solutions of glucose into the peritoneal cavity, or trying out " Soamin " on a baby with meningitis in dim-lit Miriam of old.

Cameron's out-patients were an outstanding success for three main reasons. The first was the immense esteem which he rapidly won for himself in the hearts and minds of " the Borough " ; he even attained to the supreme honour of being called " Cameron," not " Doctor Cameron " : he became a household word. The second was his unselfishness in gathering together a band of enthusiasts to help him reap the rich harvest that he himself had sown. Three or four men worked in one room together. The tumult was like a Christmas party imagined by Dickens ; but never mind a trifle like that, for never was there such an opportunity for exchanging opinions, ideas and clinical material. Anyone could bring anything of interest for Cameron to see, and elicit his views and draw on his experience. He himself would get up occasionally and walk round to see how his junior colleagues were faring ; he never, however, interfered with them. The mass and variety of material was so great in those heroic days that a man might range over practically the whole field of diseases of childhood and gather a store of experience that would last him for the rest of his life. The advantage to the patients was very great because they were spared the inordinate length of waiting which was the bane of the out-patients in some other departments at that time. A third reason for success was the self-abnegation shown by the physician in not annexing to himself all the best cases, not even under the pretext that he needed them for teaching. Moreover, he never turned over a patient to some luckless registrar because he was tired of the case, as many did and perhaps still do. For one thing he took too much personal interest in his charges to do any such thing, and for another he was too fair to his juniors. This pernicious system of turning down a patient to a junior, after his case has been seen once or twice by the great man, leads to disappointment on one side, boredom on the other, *Rep. Rep. Rep.*, and discredit to the Hospital. Cameron was without doubt quite right to abolish it, and to insist on the sustained personal interest which was part of his method. Whether we quite appreciated at the time his insight into the patient and his scrupulous kindness to us I am not so sure, but he taught us thereby lessons that we all needed badly to learn.

Meantime another of Cameron's creations—the Infant Welfare Centre—was, metaphorically, draining the morass of illness from which this flood of out-patients was derived, imperceptibly at first, but so efficiently in the end that the river became a stream and the stream a trickle. Other centres, of course, sprang up from time to time and assisted in the process, but it is important to record that Guy's was one of the first to organise an institution of this kind. Among the protagonists in the movement were Cameron himself ; Jewsbury, of St. Thomas's ; and Waller, of the Royal College of St. Katharine. These men, with some others and certain of their obstetrical brethren, formed a club, quaintly called the " Preposterous Club," which met at intervals, and there, no doubt, views were exchanged, plans put forward and mutual encouragement given in the way that is common when great movements are being born. The result to us was the foundation of the Salomons Centre, which Cameron decided in his wisdom should be part of the Hospital itself, but be managed by a separate committee of which he himself was naturally the moving spirit. It was, he hoped, to be a model of what an Infant Welfare Centre ought to be ; and what better chance was there of fulfilling this hope than by having it in his own hospital, under his own eyes ? He must have foreseen also how much a child who had fallen ill would gain by prompt and certain treatment in the Hospital, and by the following up of its case from one department to another and back again. It would also be a great advantage to the practitioner who was to do the actual work to be closely connected with the Hospital, to share in the Out-patients, and so to be in frequent contact with himself. An old house, comely and substantial at the back of Guy's, was chosen as the site ; and a very good choice it was, for it had the right atmosphere of homeliness. Many men would suppose that an Infant Welfare Centre should look like any other department of the Hospital, but this is not the case at all. I have no dount that Sewell, who thought that the family was the type of all human society, and that Beauty was a part of education, was quite right ; and an Infant Welfare Centre, being an educative place no less than a school, should express both these ideas. But when after some years the old Centre was pulled down and a new one built, these principles were completely over-ridden. The present building is ugly, soulless, utterly utilitarian and grimly suggestive of abscission of the prepuce or abstraction of the tonsil—that is to say, it is exactly the opposite in looks of what an Infant Welfare Centre ought to be. One can only hope for a better building, re-establishing the right principles, in the future Guy's.

The Royal College of St. Katharine has been mentioned already as an early Infant Welfare Centre. It has been a very successful place, and in some points it served as a model for Guy's. It draws its funds from Royal sources, is controlled and administered by the Church, and for a long while its moving spirit was a very able man, Canon Thory Gardner. I shall not be controverted if I say that between its physician, Dr. H. K. Waller, and Dr. Cameron there has been a general accord in important matters of Infant Welfare. The Church planned St. Katharine's as a settlement, a community living and working among the poor; and for the Centre at Guy's this idea was adopted, though with a difference. It too has been a self-contained community, managing its own affairs, living under its own roof, devoted to its own purpose, a family among the families round it, with a Sister-superintendent at the head; but the difference has been that Guy's is a training school for health visitors and St. Katharine's is not. The result has been that in the latter place the population has been semi-permanent, whereas with ourselves there has been a continued inflow of new health visitors to be trained and an equal outflow of the fully trained to go forth and carry on the good work elsewhere. The task of the Sister-superintendent would evidently not be an easy one, and Guy's was fortunate to secure Sister Bertha Martin, a woman of remarkable character, shrewd judgment, knowledge of humanity, and yet, with all this, the domestic qualities necessary to act as head of the family. She became a kind of local Queen Victoria, but without any of the old Queen's acerbity. The mantle of her kindness covered everyone; the door of the Centre never closed; a stream of callers came in all day, seeking and receiving help, advice and encouragement; and so the Centre became what it was intended to be, but what with many others it might not have been. After her retirement, the far from easy position of replacing her has been fulfilled with conspicuous success by Miss Coombe. The domestic side of the Centre, however, has had to be abandoned: no woman now can add the heavy toil that house-keeping has become to all the other responsibilities. I must not omit to mention that the ante-natal side has been throughout in the hands of McNair; but it is of the children, rather, that I am writing.

Both Guy's and St. Katharine's had to secure and maintain for themselves the help of the local authorities—Southwark and Bermondsey in one case, Poplar in the other—and more especially of the local medical officers of health, in which matter both have enjoyed great good fortune. Since those days the local authorities themselves have become the principal exponents of Infant Welfare, and very well they do it, as far as my experience goes. Nevertheless, it was the bodies called "voluntary," a convenient but not at all an accurate term, which initiated the movement, either mainly or altogether; and it was single men of imagination and creative ability who conceived it. I was very much struck to hear the late George Lansbury, when he was opening an important extension of the work at Bow, let fall a remark to the effect that in this country private individuals conceive, and public bodies afterwards acquire and develop; coming as it did from the mouth of a very ardent socialist, this statement of opinion had, for me at least, great force.

While these learned men were quietly and steadily pushing on with their plans there burst upon the world the strange irruption of a New Zealander, Truby King, whose name became for many persons almost a synonym for Infant Welfare. Like Sir Roderick Glossop, Truby King was a looney specialist—there were no psychiatrists to speak of as yet; and he developed an extraordinary passion for breast-feeding, an enthusiasm of a sort that rests, not upon scientific reason, but upon emotion. His disciples, moved in their emotions like himself, believed everything he said and followed him with religious fervour. He also had a most unpleasant doctrine that a child must not be handled except when it was being fed; but, on the contrary, that the moment its feed was over, it must be put back in its cot, and not touched until the next feed, all impulses to love it or play with it being sternly suppressed. That some of his childless devotees should have been emotionally moved by this doctrine is understandable, but what curious trends the man must have had himself! Even his passion for the breast was pursued with mystic rites: it was sponged, I remember, with hot and cold water alternately, to make it secrete; and I forget what else was done. To a man of warm temperament, such a man as Dr. Cameron, Truby King's suppression of natural affection must have seemed repellant; but even if this had not been so, psychological acumen would have damned the thing. The result was that the "Truby King methods," as they were called, were rejected at Guy's (and also at St. Katharine's), a fact that does not appear at all remarkable, unless you know that they were swallowed whole nearly everywhere else, including at least one prominent London hospital. Being really unsound they died away in time, having done I know

not how much harm to the infants subjected to the abstinence. But they had one other unfortunate effect: the members of the public, knowing nothing else and believing all that they were told about Truby King and his methods, supposed that he was the inventor of Infant Welfare and that his methods *were* Infant Welfare; with the result that those who were the real promoters of this important movement have never received the recognition that is their due.

I do not know whether to the man who wrought these reforms at Guy's the change that has come over the children of the Borough seems to come up to his expectations or not; but to me it appears surpassingly good, and beyond anything I hoped for. It is not difficult to see in one's mind a typical infant of, say, thirty years ago from the districts round Guy's, a puny little thing, with an old man's face, a woollen cap that gave it an elfin look, a musty smell about it often tinctured with the reek of camphorated oil, and layer after layer of garments, perhaps as many as twelve or fourteen; or that somewhat older child, flabby and water-logged, with pink, eczematous cheeks, irregular decaying teeth, large tonsils and adenoids, and a snuffly nose. Can such things be? Not now: they seem to have disappeared like an evil dream. When one sees the beautiful healthy, happy children of to-day, the line that most often comes into one's head is:—

"Hinc laetas urbis pueris florere videmus."

Impossible application thirty, even twenty, years ago! In the ill world in which we are living at present the sight of such children is one of the very few sources that there are for a solid satisfaction. Mother and child are even for a while comparatively free, untrammelled in their life together by a hundred thousand controls, safe in the arms of Venus.

The two main scourges of young children in the days gone by have virtually disappeared. Broncho-pneumonia is but a wraith; occasionally I see a mild form of it. More often a woman tells me that her child has had it, but I have only her word for it, and examination of the child reveals that it can have had but little the matter. Gone is the dreadful apparition of the leaden-coloured child, *mortuis pro mortuo*. Some of this change for the better is due to improved methods of treatment, much more to a greatly strengthened resistance. That terrible summer diarrhœa that slew more children than Moloch in Jewry, is almost a thing of the past. One wonders what has become of it: the assassin has dropt his robe and dagger and fled! Such cases as do occur show mild symptoms, trifling loss of weight, ready response to treatment and rapid recovery. The endless dyspepsias have well-nigh gone, too. A woman to-day must be a great fool if she ruins her child's digestion. No more "cows' milk atrophy," no more "decomposition," no more marasmus! How many persons must there be at Guy's now who have never seen a marasmic baby? Diseases due to shortage of vitamins have gone with them. Scurvy seems to have gone; rickets is seen once or twice a year in very mild degree, and only in those whose mothers have neglected to give them their cod-liver oil. Gross bowing is not to be seen: as for the catatonic child with beads of sweat upon his brow, he is a memory only. A laggard in reform was dental decay: suddenly it disappeared, or nearly so, quite recently. We now know for a fact what before was a conjecture—sweets! This was the adverse factor. The rationing of sweets has been a compensation of the war.

There remain unaltered the defects and deformities. "This is the foul fiend Flibbertigibbet: he gives the web and the pin, squints the eye and makes the hare-lip." Science has done nothing as yet about Flibbertigibbet, unless you count the suggestion that one of his other names is "German measles."

Breast-feeding is maintained fairly steadily among the mothers of Bermondsey and Southwark; and this is a positive gain for, if report speaks truly, in most places it is falling off. A belief in the magic properties of dried milk is one of the main factors in failure to breast-feed just now. Plain milk is regarded by the mothers with no particular wonder, but dried milk is invested in their minds with magic. Not a few medical men share this belief; yet neither of the two would suppose that a dried egg was better than a fresh one. The baby fed on dried milk, as exhibited, is obese, podgy, slumberous and smiling. It afterwards gets flat feet and knock-knees. The encouragement of breast-feeding is looked upon as important at the Centre; it was strange to read an official report on the subject by J.Ps., M.Ps., M.Cs., and a doctor or two here and there, the purport whereof was that breast-feeding did not much matter after all.

Once I said to Waller, "Which in your view is the more important improvement—the physical or the psychological?" Without hesitation he answered: "The psycho-

logical." The beauty of the child one sees appeals to the senses, the size and strength to the imagination, but the happiness and stability are the most profoundly satisfactory things. Now if it be true—and I see no reason to doubt that it is true—that the seeds of most important neuroses are sown during the very early years of life, then, inasmuch as the neuroses form now, and in the future are likely to form even more, the bigger proportion and the most distressing part of illnesses, when I assert, as I do assert, that the neuroses of childhood are dwindling rapidly, am I not uttering a prophecy of singular good for the next generation ? Of more moment, perhaps, than aught the Pythian priestess spake forth from Phoebus' tripod and grove of laurel (" Pythia quae tripode e Phoebi lauroque profatur ? ") I have not space to dilate on this topic, but at least two neuroses of infancy seem to have disappeared—an uncommon one, " habitual vomiting," and a common one, " nervous unrest "—by which was meant a yelling, screaming, scarlet imp, with taut, retracted belly, ceaselessly moving limbs, not much less ceaselessly moving bowels, a weeping mother and a failing breast. That very frequent and intractable disorder, " food-refusal," is less common, less severe and less obstinate than it was. I could readily extend this list. But what is really of more moment than the diminution in classifiable neuroses is the general frame of mind of the average child seen, cheerful, courageous, sensible and stable.

My footsteps bring me back now to the place from which I started—to Hector Charles Cameron. In a hasty and imperfect way I have sketched out the course of the silent revolution, the credit of which belongs to him. His the imagination that has conceived, his the ability that has brought forth, his the eloquence, the charm in discourse, the superb skill in teaching that have carried his ideas far and wide among persons who often have no notion whence they come. Years and years ago, when Cameron was only laying the foundations of his edifice, I had for my friend at Guy's one who has since become a famous painter. Guy's has never paid the slightest attention to her alumnus, but this is not at all surprising, because the trend of culture in Medicine is steadily downwards. The same skill that inspires his remarkable portraits in the Royal Academy and elsewhere also used to inspire his incisive verbal portraits of the staff of Guy's. He singled out Cameron from all others. " He alone," he said, " is an artist." With this high praise I must leave him, expressing my own feelings through the mouth of a favourite poet :—

" E tenebris tantis tam clarum extollere lumen
qui primus potuisti inlustrans commoda vitae,
te sequor, o Graiae gentis clecus, inque tuis nunc
fictu pedum pono pressis vestigia signis,
non ita certandi cupidus quam propter amorem
quod te imitari aveo."

(Thee, who mid such great darkness couldst first raise up so glorious a light, shedding lustre on life's interests, thee I follow, glory of the Greek race, and in thy footsteps plant my own with firm imprint, not from greed of rivalry, but for love's sake, because I fain would imitate thee.)

Guy's Hospital Clubs' Union

LAWN TENNIS CLUB

Tennis, most of all games, was seriously affected during the War period. Tennis-balls disappeared from the sports shops, who could only offer to re-condition a percentage of used balls. Matches could not be arranged against tennis clubs as their members left to join the Forces. Even tennis-shoes were unprocurable, and tennis-rackets were expensive.

With the exodus of the Medical School to Tunbridge Wells, Guy's tennis was transferred to the Nevill Club. The Tunbridge Wells L.T.C. was a much better proposition, and membership to this club was generously opened to Guy's students at a reduced rate.

The Inter-Hospitals Cup tournament ceased to be held. During the last three years five grass courts were prepared by Mr. Kirby for use at Honor Oak Park. Friendly matches were played against the other London hospital and a few clubs. Many of our members playing in the United Hospitals and London University teams.

Now that the war has ended the prospects for next year are bright. There will be first-class clubs to play against; tennis equipment should be plentiful again; the Inter-Hospitals Cup, the Arbuthnott Lane-Washbourn Cup (open to students) and the Fawcett Cup (open to members of the Technical Staff) competitions, should be resumed.

Members are reminded that most matches will be played before the Medical School breaks up for the long summer vacation. So try to get back to form early.

K. Y. KHONG (Captain).

THE BOAT CLUB

THE Boat Club is largely composed of men with previous rowing experience—there being few facilities for coaching beginners.

Thames Rowing Club very kindly allow us to use their boathouse at Putney, from which an eight goes out almost each week of the year, and spare men can usually find a place in one of the Thames' crews.

The usual regattas for which a crew is entered are the Head of the River race in March; Putney and Fulham regatta in May; United Hospitals regatta in June; and any odd races that can be arranged. This year the eight rowed at Henley, and we hope will be able to race there next year. A United Hospitals crew is entered for Weybridge regatta in August.

The annual general meeting will be held in October, and any prospective new members are invited to attend.

THE FENCING CLUB

THIS year, after five in abeyance, the Club has restarted activities, and last term saw our first full programme. We are fortunate in having obtained the services of Colour-Sergeant L. C. Clarke (late of the Royal Marines), who has, among other achievements, represented the British Army at the Olympic Games before the War, and he has worked tirelessly to produce a team, with the result that in our first matches last term, against King's and Univeristy Colleges, and the City of London School, we were rewarded with fair success.

Experienced fencers are urgently required since we hope to increase the size of the team, and have a full list of fixtures including some against Royal Marines at both Deal and Chatham, the London Hospital and Imperial College, matches which should provide us with valuable experience and some spirited fights. Regular practices will be held every week this term, and those with experience should get in touch with the captain or secretary or put their names on the list posted on the club board in the Colonnade.

There is scope, too, for those who wish to learn to fence and we need many novices to secure a strong team for the future. We would point out, though, that while we extend a cordial welcome to all enthusiasts, the art is not learnt overnight, and that in fencing perseverance is a virtue commensurate with enthusiasm. The gymnasium is open at all times for practice and regular novices' classes are held at 5 p.m. on Friday evenings. Anyone who has any equipment should bring it with them, since we are at present very short.

RICHARD NEVE, Captain.
N. H. PORTER, Secretary.

THE BOXING CLUB

DURING the last few years little has been heard of the Boxing Club. It is one of the oldest members of the Clubs' Union and one of the major sports at Guy's; it has been a source of disappointment to many that so little has been seen of it during the War. Last season, however, it made a fighting start, tying on points with St. Mary's in the Inter-Hospital competetition, and winning by a large margin the London University Boxing Cup, in which other hospitals as well as the colleges were represented. Many of our members were chosen to box against Oxford University, and those who competed won their bouts.

This year the Inter-Hospital Boxing Cup is again to be fought for. Guy's are the present holders—and future retainers, we hope. Besides this, we are arranging matches with other clubs. In these bouts the quality as well as the weights are matched.

We have been unfortunate in losing some of last season's boxers, and, therefore, if any readers are interested in boxing we would be very pleased to see their names on the list in the Colonnade and to see them in the gymnasium, no matter what their experience. We have an excellent trainer, who will teach them. I want to impress that we need new members to keep up our promising start and to maintain the tradition of Guy's Boxing Club. MICHAEL O'REILLY, Hon. Sec.

THE PHYSIOLOGICAL SOCIETY

THE late Professor Pembrey founded the Physiological Society in 1900, regarding it as a means whereby the students' interest in physiology could be intensified, and an acquaintance could be made with public oratory and business procedure.

The Society is open to all Guy's students, and those new to the Hospital are urged to attend its meetings, held fortnightly throughout the winter and spring terms. Here original papers of physiological interest composed by students are presented, and discussion follows. The Pembrey Prize is awarded annually to the author of the most meritorious paper.

It has been impossible during the War to continue such social activities as the annual dinner and the pre-meeting teas, but it is hoped that these may be soon reintroduced.

It is intended to present ten papers in this 1945–46 Session, and such topics as " Bacterial Metabolism," " Speech " and " Genetics " will be dealt with this term. The first of the papers concerning " Nucleoproteins and Some Fundamental Processes " will be read on October 18th, 1945, at 4.15 p.m., in the Physiology Theatre.

L. C. KREEGER, Hon. Sec.

THE STUDENTS' UNION

FUNCTIONS.—The Students' Union aims to maintain the social and cultural life of Guy's students and to represent their views in every way. It is represented on Guy's Theatre Club Committee, the B.M.S.A. committee; Matron's Social Committee at Orpington; the Nurses' Social Committee at Guy's; and is affiliated to the Clubs' Union and the B.M.S.A. Its official newspaper is *Pulse*.

Elections.—The individual groups of preclinicals and " appointments " of clinicals elect their own representatives before the general meeting of October 16th; the general meeting elects the secretary and chairman.

Last Year.—A revue, dances, talks, debates and surveys of student opinion were arranged. Recommendations were made on student health and teaching conditions in the Hospital.

Next Year.—We are attempting a complete revival of the Debating Society; and another Students' Union revue should materialise before the preclinicals' Christmas vacation. The Students' Union big dance is on October 26th, 1945, and as it coincides with a gathering of B.M.S.A. members from all parts of the British Isles, at least one hundred of these representatives will be present. A pamphlet and map for freshmen is being prepared; the possibilities of film shows within the Hospital are under review; talks of general interest are to continue.

The support of every student is needed and all suggestions are welcomed.

M. H. LESSOF. Hon. Sec.

NON AFFILIATED BODIES

THE CHRISTIAN UNION

SINCE 1849 there has been a Christian Union at Guy's, seeking to unite those who believe in Jesus Christ as Saviour and to bring this knowledge to others. The student members belong to the London Inter-Faculty Christian Union, and form part of Guy's Hospital Christian Union, whose membership is open to all who work in the Hospital.

All are welcome at our meetings in the Chapel, which we use by kind permission of the Chaplain. On Monday, at 5 p.m., there is a Bible study and a prayer meeting on Friday at 12.30 p.m. Further details of meetings are posted on the Christian Union notice-board in the Colonnade. J. R. B.

THE THEATRE CLUB

THE Guy's Theatre Club, as a constituted body, has been in existence but a short time. It was founded by a group of enthusiasts who, in the last few years, have produced many plays at Guy's and in the Sector, and who felt the need for a permanent organisation to represent their interests at Guy's as well as to smooth the path of the would-be producer. Because of its youth the club needs the support all those students, new and old, who are eager to play their part. There is room, not only for actors, but also for producers, stage-managers, technicians, stage-hands and programme-sellers. If you wish to join our ranks, leave a note for me in the Colonnade, with your name and (theatrical) aspirations. Do not be shy if you have no experience; our programme for the forthcoming year is not yet fully arranged, so everyone will have his chance. Membership is open only to members of the Clubs' Union, although we are not an affiliated body. I shall be pleased to answer any queries you may have, and, if necessary, to arrange a meeting for newcomers to the Club.

To those readers who will not wish to take an active part in our productions this appeal is addressed; when the Guy's Theatre Club presents an entertainment, turn up in all your numbers and give us your support. We trust you will not be disappointed.

JOHN G. STEBBING.

Correspondence

MALARIA AT GUY'S.

To the Editor of the GAZETTE.

SIR,—I was not surprised to read of the cases of malaria at Guy's. To quote from my recent article on "Changing Clinical Horizons":—

> "Anopheline mosquitoes are widely distributed in this country, but fortunately not infected. Yet whenever British troops have been engaged in wars in malarious countries their return home has usually been followed by local outbreaks among the civil population in the neighbourhood of garrison towns; hence the importance of rendering sufferers parasite-free."

In this country, especially after the recent war, I would like to emphasise the extreme importance of taking histories carefully. "Have you ever been abroad? Where? In what particular places have you lived (in chronological order)? When did you first go abroad? When did you return to this country? Where have you lived in this country? Where do you live now?"

These data, in conjunction with a knowledge of the distribution of the various tropical diseases and the patient's present symptoms, are very helpful in suggesting the line which investigations should take. As an example which I have quoted before, the form of malaria in the Andaman Islands is almost entirely of the quartan variety.

In Case III quoted in the article under reference, although it is stated that the patient "had had twenty-two attacks of malaria in nine years" and that B.T. parasites were recovered from the blood, there is no mention of the countries where he had lived, the length of time he lived there and how long it is since he left an endemic area. The usual experience is that if a patient who has been infected with B.T. malaria has been living outside an endemic area—*e.g.*, in this country, for a period of three years, the attacks cease and the blood is parasite-free. It is therefore very important to know what opportunities there may have been for re-infection. This raises the old question of the so-called "latent malaria" and of "Where do flies go in the winter-time?"—*i.e.*, where the parasites hide between the attacks. If no parasites are found in the blood of a suspected case after careful and repeated examinations, an injection of 1 cc. of T.A.B. vaccine will make them appear, if they are there at all.

Moreover, the authors of the paper simply state that "B.T. parasites were found." They do not say whether they found ring-forms, schizonts or gametocytes; and if the latter, whether male or female and the relative proportions of each. If the first or second they would be in the peripheral blood (in M.T. schizogony takes place in the capillaries and not in the peripheral blood except in massive infections, when it is a sign of grave import), but inside the body of a red cell. Gametocytes would be free in the blood. I mention this because I have often seen students of my own and even pathologists with little experience of malariology indicate an abnormal white cell and ask, "Would you call that a gametocyte?"

I think the admission of malaria cases to Guy's lends point to my paper's concluding paragraph as to the need for greater knowledge of tropical diseases by practitioners in this country and to care and watchfulness if anomalous conditions should be met with, *especially with a history of living abroad.* It looks to me as though for a long time to come we must make routine questions as to living abroad and examination of blood and stools a regular part of our investigation of illness, having regard to the large numbers who have served in tropical countries and the coming increase in air travel.

Incidentally, the abdominal pain complained of by Case III would make me think of M.T. malaria, the abdominal form of which is a well-known clinical entity. It might still be worth doing further searches for *P. falciparum.* Sometimes many slides may have to be searched from end to end until at last a crescent is found. It must not be forgotten that double infections *do* occur, but the character of the temperature chart should put one on the track.

Yours, etc.,
"UNCLE HARRY."

Sport

Cricket

RETROSPECT.

In results the team broke even, two draws being very much in our favour. The opening pair, Williams and Munro, were the two most successful batsmen, but although often making high scores they lacked the initial aggression indicative of half-day cricket. Often, to counteract this slow start, Graham, Garland and Harvard-Davis were obliged to treat the bowling with a degree of disrespect not merited by the attack. Graham and Harvard-Davis were the only two batsmen who dealt correctly with a bad ball early in their innings: Garland was often out when selecting the wrong ball to hit.

The bowling was on a high plane, Trist and Carton-Kelly opening the attack, but Trist was only able to find his last year's form in the early part of the season and in the last few games, a central period being unproductive, during which time he wielded a successful bat. Carton-Kelly's bowling made a considerable advance on previous seasons and improved as the season wore on. His captaincy was at all times excellent, his handling of the bowling leaving little to be desired and his example in the field a stimulus to the side. Webb, with his medium spinners, enhamced his considerable reputation gained in so short a time last year.

Of the new bowlers O'Driscoll proved fast and effective, dismissing many good batsmen and returning good figures. The fielding of the side was keen, Evans, Trist and Munro being outstanding close in and Sheerboon as usual excelled at cover.

E. W. G.

AVERAGES.

	Innings	*Not out*	*Runs*	*Highest score*	*Average*
I. D. Williams..	20	2	387	66*	21.50
I. A. H. Munro	20	1	406	74	21.37
W. M. Garland	18	3	268	49*	17.87
E. W. Graham	19	1	294	64	16.33
R. Harvard-Davis	13	–	204	40	15.69

* Not out.

	Ovs.	*Mdns.*	*Runs*	*Wks.*	*Ave.*
R. Harvard-Davis..	21	1	100	12	8.33
H. M. C. O'Driscoll..	54	8	145	14	10.36
L. D. Carton-Kelly..	207.5	45	503	45	11.18
A. E. Trist ..	206.3	32	616	43	14.32
W. B. Webb ..	178.4	34	568	38	14.95

Rugby

SEASON 1945–46—October Fixtures

FIRST XV.

Date 1945.	*Ground*	*Opponents*
Oct. 13..	H.O.P.	Old Merchant Taylors
,, 20..	Thames Ditton	Old Paulines
,, 24..	H.O.P.	Cambridge Univ.
,, 27..	H.O.P.	Aldershot Services

Entry of Students, October, 1945

MEDICAL.

FIRST YEAR STUDENTS.

Name.	*School.*
Addy-Taylor, T. I.	Oundle School.
Alldridge, D. G. E.	John Fisher School, Purley.
Bellis, T. G. L.	Friars School, Bangor.
Brook, C. P. B.	City of London School.
Catlin, R. J. O.	Wembley County School.
Cliffe, D. J.	Dulwich College.
Craft, M. J.	Brentwood School, Essex.
Cohen, L.	Cardiff High School.
Comper, J. W.	City of London School.
Davies, D. J.	Llandovery College.
Dunn, A. A. A.	Ampleforth College.
Dunn, C. R.	Taunton School.
Fisch, G. H.	Lincoln School.
Forrest, D. W. G.	Bootle Secondary School.
Forrester, A. T. T.	Bedford Grammar School.
Fram, A. I.	Nottingham High School.
Fraser, I. H. C.	King's School, Canterbury and Sevenoaks.
Goodfellow, J. W.	Wellington School, Somerset.
Gregory, B. P.	Bishop Stortford College.
Gillard, J. C. H.	Hereford High School.
Hart, T. S.	Dulwich College.
Hirsch, D. O.	King's College School, Wimbledon.
Holden, G. C. A.	Normanton Grammar School.

Howells, K. E.	Newport High School.
Jeffs, J. V.	Lewis' School, Pengam.
Jelleyman, J. C.	Colfe's Grammar School.
Jenkins, P.	Ellesmere College.
Jones, I. M.	Dolgelley Grammar School.
Jones, V. R.	Bible College School.
Katz, T. G.	Ellesmere College.
Lovell, D. R.	Bromsgrove School.
Lewis, J. B.	Sutton Vallance School.
Lyon, P.	Plymouth College.
MacLachlan, K. E.	Royal Grammar School, Guildford.
Martin. J. A. M.	Magdalen College School, Brackley.
Masters, E. J.	Sevenoaks School.
Minkovitch, O.	Dr. Challoner's Grammar School.
Moffat, R. J. R.	Whitgift School.
O'Brien, P. M. J.	St. Edmund's College.
Palmer, J.	Judd School, Tonbridge.
Pelmear, P. L.	Truro School.
Price, A. H. K.	Limber House, Nottingham.
Pritchard, J. E.	Epsom College.
Pryn, W. J.	Malvern College.
Richards, S. H.	Machynlleth County School.
Robertshaw, A. S.	Morecambe Grammar School.
Rowson, A. H.	Ackworth School.
Ruggles, P. W.	Preston Manor County School.
Russell, A. R.	McGill University, Montreal.
Sharpe, I. M.	Brockley Grammar School.
Stafford, M. D.	Weymouth Grammar School.
Stoker, D. J.	Oundle School.
Sunderland Cooper, A. F.	Leys School, Cambridge.
Smith, P. J.	Sutton High School.
Thomas, T. G.	Rydal School.
Thompson, W. W.	Arnold School, Blackpool.
Tweed, W. M. E.	Wellington College, New Zealand.
Waite, J. F.	Old Clee Grammar School.
Watts, A. V.	Scarborough High School.
Wells, R. S.	Wellington School, Somerset.
Willis, J. H.	Stoneyhurst College, Blackburn.

SECOND YEAR STUDENTS.

Name.	*School.*
Bluett, D. G.	Sevenoaks School.
Boenheim, T. K. H.	The Hall, Hampstead, and Leighton Park.
Carmac, J. C.	Epsom College.
Cook, P. J.	Kent College, Canterbury.
Dinmore, P.	Sevenoaks School.
Foley, J.	Westminster School and Imperial College of Science.
Gould, W. L. P.	Keble College, Oxford.
Goulding, R.	Newport Grammar School, Essex.
Grove, S. S.	Hottentots-Holland High School and University of Cape Town.
Harrington, J. L.	
Hughes, J. W.	Culford School.
Kendall, P. H.	Epsom College.
Mackrill, M. J. R.	Royal Grammar School, High Wycombe.
MacQueen, I. J.	Stationers Company School and Birkbeck College.
MacWilliam, J.	Kingswood School.
Michell, R. C.	Lewes County School for Boys.
Nauth-Misir, R. C.	Queen's College, British Guiana.
Owen, T. M.	Friars School, Bangor.
Phillips, S. M.	Wallington County and Birkbeck College.
Powell, R. J.	Penarth Secondary School.
Reader, A. M.	King's College School, Wimbledon.
Russell, P. S. B.	Purley County School.
Schapira, H.	Laura Place School and Regent Polytechnic.
Skinner, P. A.	Emanuel School.
Sturdy, D. E.	Llandyssul County Secondary School.
Thompson, M. G.	Emanual School.
Williams, R. I. J.	Newport High School.
Worms, K. G.	Leighton Park School.

CLINICAL PERIOD OF STUDY.

Name.	*School.*
Allen, R. D.	Haileybury and Trinity College, Cambridge.
Allsup, N.	Queen Elizabeth Grammar School & Caius College, Cambridge.
Davies, H. E. F.	Bridgend County School and Glamorgan College, Cardiff.
Goldstein, A.	Birkbeck College and St. Catharine's College, Cambridge.
Hatton, M.	Epsom College and Christ's College, Cambridge.
Hewett-Clarke, A. H. R.	Marlborough and Trinity College, Cambridge.
James, I. P.	Aldenham and Pembroke College, Cambridge.
Jefferson, A. B. C.	Manchester Grammar School and Clare College, Cambridge.
Owens, D. N. H.	Epsom College and St. John's College, Cambridge.
Southwell, R.	Bridlington and St. John's College, Cambridge.
Southwood, W. F. W.	Charterhouse and Trinity College, Cambridge.
Sugden, W. S.	Uppingham and King's College, Cambridge.
Talbot, C. H.	Leighton Park School and St. John's College, Cambridge.
Tayler, R. G. O.	King's College, Canterbury, and King's College, Cambridge.
Wallace, K. R.	Bromsgrove School and Clare College, Cambridge.
Walsh, W. R.	Queen Elizabeth Grammar School and Gonville and Caius College, Cambridge.

DENTAL.

PRE-MEDICAL AND FIRST B.D.S. STUDENTS.

Name.	*School.*
Ashby, M. F.	City of London.
Beresford, G. P.	St. Albans School.
Campbell, D. S.	Thames Nautical College.
Chapman, K. L.	John Bright County School, Llandudno.
Cogan, J. O.	Kingswood School.
Conroy, E. M.	Mount St. Mary's College, Spinkhill.
Cracknell, J. A.	King's School, Taunton.
Crine, G. V.	Douai School, Reading.
Dickens, J. J.	De Aston School, Market Rasen.
Dorrington, R. N.	Witwatersrand University.
Dunmore, S. S.	King James' Grammar School, West Yorks.
Du Plessis, A. N.	South Africa.
Fullam, J. L. R.	St. Edwards School, Simla.
Gazet, J. C.	Stevenage Grammar School.
Gilbert, K. J.	Preston Manor County School.
Gillet, H. E. H.	Nautical College, Pangbourne.
Head, G. V.	Borden Grammar School.
Hitchcock, A. G.	St. Albans School.
Hole, H. C.	Brighton Grammar School.
Hutchings, J. T. A.	Clark's Modern School, Ilford.
Jackson, G. J.	St. Paul's, Hammersmith.
Leech, A. P.	Northgate School, Ipswich.
Levene, H.	Highbury County School.
Levenson, J. G.	Dynevor Secondary School, Swansea.
Lloyd, D. V. S.	Llandovery College.
Lloyd, T.	Narberth County School.
Lougher, T. F.	St. Joseph's College, S.E.19.
Lovett, M.	Highbury County Secondary School.
Marsh, M. J.	Cardiff University.
McEwen, C.	Epsom College.
Owen, C. B. H.	Aberdare Boys' School.
Price, A. B.	Christ College, Brecon.
Reed, W. J. A.	Sutton County School.
Reynolds, J. A.	Frimley and Camberley County School.
Rich, B. C.	Whiftgift School.
Ryan, W. D. V.	County Grammar School, Wallingford.
Saville, P. J.	St. Egbert's College, Chingford.
Smith, B. N. J.	St. Edward's School, Oxford.
Smith, P. C.	King's College, Wimbledon.
Steele, C. A. P.	Wells Cathedral Grammar School.
Staub, J. J. F.	Mauritius.
Thompson, G. F.	Emanuel School.
Tisdall, J. S.	King's School, Canterbury, and West Buckland School, Devon.
Tweddle, E.	Selbright School, Wolverley.
Vowles, C.	Epsom College.
Watson, W. H.	Ratcliffe College, Leicester.
Williams, G. M. J.	City of London School.

FIRST YEAR AND SECOND B.D.S. STUDENTS.

Name.	*School.*
Boswell, D. R.	Epsom College.
Grimer, P. T.	Wembley County School.
Kaye, M.	Owen's School, Islington.
Keen, M. M.	Raines Foundation School.
Lawson, B. E.	St. Lawrence College, Ramsgate.
Leckie, J. C.	Bridgnorth Grammar School.
Leigh, A. A.	Haberdashers' Aske's School.
Richards, G. D.	Port Talbot County School.
Roth, I. L.	Ilford County High School.
Scott, H. L.	Epsom College.
Shaw, J. D. R.	Fettes College, Edinburgh.
Stocker, A. H.	Haberdashers' School, Hampstead.
Woolf, B.	Regent Street Polytechnic.

Hospital Information, etc.

Notice

STUDENTS' UNION.

The bi-annual general meeting of the Students' Union will be held in the Physiology Theatre on Tuesday, October 16th, at 1.15 p.m.

Change of Address

H. J. B. Atkins, M.Ch., F.R.C.S. Consulting: Nuffield House, Guy's Hospital. S.E.1 Private: Taggles, Carters Green, Harlow, Essex. (Tel. Nos.: Hop 1864 & Matching51.

C. G. Baker, O.B.E., M.D., Selby Oak Hospital, Birmingham.

R. W. F. Brotherton, Major, A.D. Corps, 52, London Road, Twickenham.

Donnell, J. H., B.A., M.B., Brownsea View, Brownsea Road, Sandbanks, Bournemouth.

Hinchliff, C. J., L.D.S., R.C.S., 29, Ridgeside Avenue, Withdean, Brighton, 6.

S. McK. Saunders, Col., R.A.M.C., c o Glyn, Mills & Co. (Holt Branch), Kirkland House, S.W.1.

C. P. Symonds, M.D., F.R.C.P., Change of telephone number, Welbeck 1076.

H. M. Worth, M,R.C.S., L.D.S., 394, Avenue Road, Toronto 5, Canada.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1494 *27th October, 1945* *Ninepence*

PASSIM

"MUDDLING through," the phrase used so proudly by the British people to describe their miraculous resurrections from graves they had already dug for themselves, is reputedly a national policy. In truth it is often enough a policy, of sloth and inertia redeemed only by improvisation, compromise, good luck, good humour and much hard work, overtime; the essential for success of the muddle-through policy, in fact, is a periodical clean sweep or minor revolution, a Magna Carta or a Reform Bill. It is time for just such a revolution in the management of the student life at Guy's. This society is at present ordered by an organisation as outmoded and complex as bureaucracy itself, and indeed it is this very complexity that may well account for its previous relative immunity from criticism. The organisation of which we write consists of a number of committees, grown up, though not modelled by the years, until we have at the present time the following bewildering collection—the Clubs' Union Council, the Students' Club Committee, the Students' Union, besides other bodies more indirectly concerned, the Medical School, Catering Company and College Committee, the latter now in abeyance. It is significant that many of these bodies are permutations of nearly identical groups of words, for they differ largely in their powers, partly in their membership, somewhat in their methods, but in their final aims hardly at all. Such multiplicity of committees has not produced co-ordination, neither has the divorce of many of them from executive power and finances brought forth constructive action or economy. For only too often, purpose and purse-strings have sat not together at the conference table.

In the spacious times of thirty, twenty or even ten years ago the abundant amenities of social life could be more easily plucked and this haphazard reproduction of committees was tolerable; but now with so much lost already and so much to build up, the whole organisation should be repaired; consequently, the information that a new Co-ordinating Committee has been formed for this purpose, drawing its membership from existing bodies, is very welcome.

The constitutional membership of the new committee will be ten, comprising the Dean, the Warden of the College, the Superintendent, the Clerk to the Governors, two representatives from the Clubs' Union Committee, two from the Students' Club Committee and two from the Catering Company's Committee. Its aims are constructive rather than associated merely with the continued running of student social amenities in their present form. It will also effect a unification of responsibility, for from now on it must be credited for any or many of the improvements that may be made besides, and one must be mindful of the great difficulties that it will face, being blamed for possible failures; and the nature of its constitution should allow the opinion of every individual to bear the weight it deserves by representation through the bodies which it co-ordinates.

Whatever proposals the members of the new committee may make, or if they are given adequate powers, whatever the plans they execute, it is hoped that news of these will reach the public ear in advance, whenever possible. Black secrecy shrouds too much of the proceedings of these social committees, concealing harmless information from those whom it concerns most. Moreover, it is right that all fair report of the Hospital should be spread abroad.

"A committee has been formed." This phrase may presage much talk; but it is no promise of action. Nevertheless, the constituted membership of this new body, its expressed aims and its future powers hold forth sound reason for hope.

We are pleased to join with readers in congratulating Dr. E. R. Boland on his appointment to the post of Dean of the Medical School. At the same time we would like to express our regrets at the retirement of Mr. T. J. Evans from that position, together with our appreciation of all his fine services for the School during his eight years of office, six of them years of great difficulties and labours thrust upon him by the War.

We would like to use these columns to wish Miss Florence Wittrick, of whose work an appreciation appears in this *Gazette*, a very happy retirement. At the same time we welcome back to the Hospital Mr. T. B. Layton, who has been released from duties with U.N.R.A.A. and now resumes activities at Guy's. While serving with U.N.R.A.A. his last appointment was Medical Superintendent of the Hospital at Belsen.

Obituary

ROBERT CLARK.

ROBERT CLARK died on October 16th, 1945, a fortnight after he had retired from the post of head mechanic in the Dental School. Since he had held the position for thirty-seven years he was known to literally generations of Guy's men who will remember him with affection, and they will feel that Guy's will no longer be the same place without him, for Clark was identified with the carefree period of the dental student's life in the Mechanics' Laboratory, which he ruled with the majesty of an autocrat. But an autocrat who enjoyed seeing or, as it usually was, hearing high spirits in his subjects; few will forget their choral triumphs in the Lab.

Clark never forgot a face, and a name but seldom. He usually knew far more about a man than he or anybody else suspected. His judgment was shrewd and his opinion valuable. He was keenly interested in his students and especially in the results of their Mechanics' examination, and it is gratifying to recall that for the five successive examinations preceding his retirement he achieved his ambition of a pass-list of 100 per cent.

Clark was due to retire early in the War, but he carried on during the difficult years that followed. He moved with the school to Tunbridge Wells, where he lived under conditions which to a man of his years used to home comforts must have been extremely unpleasant. His grumbles though were always of the type that provoked laughter, for his sense of humour overcame everything. His humour was of the dry Scottish variety and, like Fontanelle, he did not always "go ha-ha" when he laughed. This, while it perplexed some, delighted the initiated.

All old Guy's men will best remember Clark's entry in the mornings; his rolling progress down the Lab, the whistle that brought all the Lab. boys—one of whom was always called Tom—scurrying, one to hold his paper, another to receive his coat and another his hat, and they will sigh for the things of the past and will feel deeply the loss of a friend.

J. W. M.

An Appreciation

MISS FLORENCE WITTRICK.

"SISTER WITTRICK has left Guy's Hospital." Such simple words, but what a lot they contain. A personality has gone from the Guy's nursing staff that pervaded it as few have done in the past.

Miss Wittrick entered for training at Guy's Hospital, 1910 to 1913, gained outside experience with the Guy's Trained Nurses' Institution for a year, and was then appointed a Sister at the Hospital.

Tall and distinguished in appearance, with a faintly amused smile—as a Sister she inspired her nursing staff and the young medical men who worked in her ward, with an admiration for her nursing skill coupled with a certain awe of her silver tongue that could lightly wrap a sarcasm. For many years she held the post of Sister Charity in Sir Alfred Fripp's Female Surgical ward, where she gained the confidence and affection of her patients and their relatives. When in 1925 she took over the cubicled paying

ward, Bright, then situated where the Children's wards now are, on the third floor of the Medical Block—the new Sister Bright became an immediate success, not only as a fine nurse and ward administrator, but as a social hostess to the private patients' many visitors and friends. The Visiting Medical Staff, whose professional interests she studied in every way, always found a welcome cup of tea and a respite in her sitting-room.

In 1935 when Nuffield House, the private block of seventy beds was opened, she became the obvious choice as its first Lady Superintendent. Her floor Sisters and Nursing Staff benefited from the sound organisation and nursing schemes which she laid down, and her patients relied on her and eagerly looked forward to her visits.

Then came the war—and the autumn of 1939 saw the partial dispersal of patients and staff to the base hospitals, and the appointment of the Matron as a Sector Matron and the Superintendent as Hospital Officer of the E.M.S., with headquarters at Orpington in Kent. At the end of the year Miss Cawthorne, the first Assistant Matron and Deputy Matron moved on to a Matron's post elsewhere. It was by this time clear that an Acting Matron was required, and Miss Wittrick, after some discussion, reluctantly consented to fill the post, doubting her powers of organisation and staff management on a large scale. How unnecessary were her doubts has been apparent to all who have come in contact with her.

Her constructive ability, her sense of humour, her wise understanding of the human problems of all grades of workers in the Hospital, her instant decision in urgent matters, and her personal courage and example during the air-raids, have been of great benefit to Guy's. No Matron could have had a more loyal and exceptional understudy. In June, 1945, His Majesty awarded her the M.B.E. for devoted service.

Miss Wittrick retires to her home county of Norfolk taking with her the good will and affection of many generations of Guy's men and women. Her loss to the social life of the Hospital is great. She was never too tired to welcome a Guy's man or woman, or to give a helping hand in any difficulty—and her room in Nuffield House had become a rallying ground and a meeting place, and a place of refreshment. She will never be absent in spirit from the Guy's family, and Thomas Guy's Hospital has been enriched by her presence. May every happy augury attend her and be fulfilled in her retirement.

E. E. P. MacM.

Digitalis

By MAURICE CAMPBELL, O.B.E., M.D., F.R.C.P.,

Physician and Physician i/c Cardiographic Department, Guy's Hospital.

A Lecture delivered at Guy's Hospital Medical School on Friday, March 9th, 1945.

GENTLEMEN,—When I was a boy most chemists' shops still displayed their large coloured bottles going back to mediæval times, and I think I pictured those bottles, which were probably made of coloured glass and contained only water, as holding valuable remedies for all sorts of different diseases. That is still the picture that your patients will have of your work. Their idea is that for any disease there is a particular remedy, and if you do not find it you are a poor doctor; and if, having found it, you do not cure them with it, they will simply say that you are ignorant of the right method of treatment.

When Osler wrote the early editions of his text-book—among the most famous text-books in medicine—he drew attention to the fact that there were only about five remedies of that kind—iron for chlorosis and hypochromic anæmia, quinine for malaria, and a few others. We have made advances since then, with the modern arsenicals for syphilis, and the sulphonamide group with their specific action in a number of infections, and again penicillin. At the moment we are in a period when one feels that many new discoveries along these lines may be made, so that we are getting much nearer to this lay view of what we ought to be able to do with a specific remedy for each disease.

You can think of many instances, however, where we are quite helpless in that direction. The most outstanding one is still tuberculosis. All the new researches on particular drugs have failed in that direction; but so much success has come along other lines that it no longer seems impossible for us to reach that ideal.

Digitalis, which I have chosen to talk about to-day, comes well into this group. It is a specific treatment for auricular fibrillation. With one or two exceptions I have never seen fibrillation where one could not get satisfactory results with digitalis. This is so certain that if one sees a patient with a rapid uncontrolled heart rate and puts him on digitalis and the heart continues rapid and uncontrolled, one can generally say that it is not the fault of the drug or of the theory behind it, but that the patient is not taking the medicine or the particular form of digitalis given is inert.

William Withering is given the credit for the introduction iof dgitalis. As a rule when a man's name gets attached to a particular subject in that way it will be found that he has done much more than simply introduce a new drug. Withering's book, although written in 1785, contains a great deal about digitalis of which many doctors to-day are still ignorant and fail to take advantage in their ordinary work. I am going to quote one or two passages from his book to show you how modern his outlook is, and I shall come back at various points to things that he mentioned and show you how, although more has been learned about them in some directions, his conclusions are fundamentally sound.

On the title-page of the book William Withering is described as " Physician to the General Hospital at Birmingham." The book is called *An Account of the Foxglove and Some of its Medical Uses, with Practical Remarks on Dropsy and Other Diseases*, and it was published in 1785. He says :—

> " The use of the foxglove is getting abroad, and it is better the world should derive some instruction, however imperfect, from my experience, than that the lives of men should be hazarded by its unguarded exhibition, or that a medicine of so much efficacy should be condemned and rejected as dangerous and unmanageable."

He adds that " Time will fix the real value of this discovery." He has been very well justified in those remarks in the introduction of the book by the enormous amount that has been written and done on digitalis since that time. One of his conclusions which I think is entirely justifiable—in fact, I have stated it to you in other words by saying that digitalis is an almost perfect remedy for fibrillation—is that it has a power over the motion of the heart " to a degree not yet observed in any other medicine." He describes cases in which the pulse is feeble and remitting, and enters into details from which, although this was a hundred years or more before the discovery of auricular fibrillation, you will not have much doubt that he is describing patients with that condition.

I shall come back to this later on when I deal with the question of over-dosage. But he also had other valuable things to say about the action of digitalis :—

> " Foxglove when given in very large and quickly repeated doses occasions sickness, vomiting, purging, giddiress, confused vision ; objects appearing green or yellow : increased secretion of urine, with frequent motions to part with it, and sometimes inability to retain it ; slow pulse, often as low as 35 in a minute, cold sweats, convulsions, syncope, death."

All this can be illustrated in digitalis poisoning. One can give a more scientific explanation of what is actually happening in many of these cases, but he observed very accurately many of these points. And, finally, a last quotation :—

> " Let the medicine therefore be given in the doses and at the intervals mentioned above—let it be continued until it either acts on the kidneys, the stomach, the pulse, or the bowels ; let it be stopped upon the first appearance of any one of these effects, and I will maintain that the patient will not suffer from its exhibition, nor the practitioner be disappointed in any reasonable expectation."

The details of that particular sentence will really give you the main part of what I am going to try and talk about to-day, what the quantity should be, and how you should use it. I would draw your particular attention to his second sentence : " Let it be continued until it either acts on the kidneys," and so on, until you get your effect. Until that happens you should go on with your increasing dose of digitalis, and then you have to consider the question of stopping it for a time and starting again with a smaller maintenance dose. That is the problem that comes before you.

It would be more logical to start with the untreated patient who comes up with failure and rapid fibrillation, and to say how you should start his treatment, but I think it would be easier for you if I took the later stage first, and talked rather about the maintenance dose in a patient who is digitalised and see what the principles are

for keeping him right, coming back later to the more difficult question of getting the drug started correctly.

Most of what I am going to say will apply to cases of fibrillation. Shortly, at the end of the lecture, I shall speak about the use of digitalis in other conditions, but if you understand it in relation to fibrillation you will be able to see its use in other conditions because all the principles are just the same.

VARIETIES OF DIGITALIS PREPARATIONS.

First as to the forms in which you can use it. Digitalis comes from the leaves of the foxglove, and extracts of the dried leaves are still one of the most effective remedies. The ordinary tab. dig. fol. of the *Pharmacopœia* is simply the dried leaves cut up, the leaves being taken at a particular time to get the highest potency and some attempt at standardization. Most forms of digitalis produced by any reputable firm are sufficiently standard to give you good results, and I do not think that extreme accuracy of standardisation and checking up in so many cat-units to see what the strength is is really of great value, because in every patient who comes before you you have to find out the right dose of the particular preparation you are using.

I put that preparation first, not only because it is an old one, but also because it is one of the best and much the cheapest, and if a patient is going to take digitalis for many years, as a patient with fibrillation will have to do, cost becomes significant, either to the patient himself or to the hospital.

The second most important digitalis preparation is the tincture. That is simply an alcoholic solution of the same leaves, and the *Pharmacopœia* gives 10 minims of the tincture as being equivalent to one grain of the leaves. With great hesitation I differ from the *Pharmacopœia*; I think you will find in your own experience that the extract from the leaves is relatively more powerful than that, and that it really corresponds to about 12 to 15 minims of the tincture. Therefore, from an examination point of view, I should like you to remember 10 minims of the tincture compared with one grain of the leaf, but from the practical point of view, in treating patients afterwards, you will want to regard one grain as more nearly equivalent to 12 or 15 minims.

Personally I think it is a mistake to try to remember the doses of many drugs. I should allow you all to go to the examination with a *Pharmacopœia* in your pocket. The type of man who is ready to risk a patient's life by relying on his memory for what the dosage of a drug should be is not suited to be a doctor. After a time you get so familiar with the drugs you use that you are safe in using them in all sorts of cases, but I have no hestiation still in looking up the doses of certain drugs that I do not give frequently. On the other hand, some drugs are so much in ordinary everyday use that even by the time you are getting qualified you ought to be familiar with them, because you have seen so many patients with them. Digitalis, morphine, and the sulphonamides are good instances of preparations the doses of which you ought to know a good deal about even before the examination stage.

I am only going to mention one other preparation strictly comparable—namely, Nativelle's digitalin. This is a French preparation and not available in war-time, but it has established such a valuable position and is liked by so many people that I have no doubt it will reappear and be used widely. It is a very much more concentrated extract of the leaves, so that 1/600th of a grain of digitalin corresponds to one grain of the full leaf.

These three preparations are the only ones I am going to talk about of that type, and I shall give the dosage for the tinctures and you can convert to the others if you want to use those. There are a great number of other preparations of digitalis that are good and reliable, and I do not want to prevent some of you when you get into practice from using other preparations, but if you use a large number of them, the latest depending upon which commercial firm has most recently visited your surgery you will never learn very much about any of them. Mackenzie said that he only knew how to treat a patient who had fibrillation with tincture of digitalis; his life had not been long enough for him to learn how to use the others: and he bore that out by misquoting the strength of Nativelle's digitalin. Therefore I urge you to stick to a very small number of preparations. When you find a particular patient not doing well do not turn away and try some other form that you have not used before. Just think why he is not doing well on the particular preparation you are using, so that you really do get a large experience of that particular form of digitalis.

EFFECTIVE CONTROL OF THE DIGITALIZED PATIENT.

Auricular fibrillation is common enough for you all to have experience of it frequently and constantly, and there is no dount that in most cases digitalis makes the whole difference whether a patient with fibrillation can lead a reasonable life with a moderate amount of activity or whether he remains on the borderline of failure most of the time. Therefore you will get plenty of patients upon whom to use it, and it is satisfactory enough in its effects for your reputation to be much influenced by the ability with which you use it.

When you come to the average patient you will find that about 10 to 15 minims of the tincture three times a day is the ordinary amount that is needed to keep him in a satisfactory condition. You will have to find that out in different cases because the dose does vary a good deal, and you have the rather unusual position that a patient who needs a smaller amount is not less ill than one who needs a larger amount. Take two cases of diabetes: one needs 10 units of insulin a day to balance him, the other needs 50; the latter is a much more serious case and has much more advanced diabetes. But the same thing is not true with auricular fibrillation, and often as a patient gets worse he will need less digitalis than he did earlier. The reason is that it is not the amount of digitalis given by the mouth that directly influences the patient; it is the amount that remains in the body, and that is the balance of what you are giving and what the patient is excreting. Very often as he gets worse, with congested kidneys and some failure of renal excretion, he excretes very little of the digitalis you give him, so that a smaller dose will produce the right balance. It is this question of the balance between the amount given and the amount excreted that has led to so much unnecessary anxiety about digitalis poisoning.

If you are asked to give an instance of a drug with a cumulative action that may lead to over-dosage and poisoning, possibly digitalis is one of the most likely to come into your mind, and it is perfectly true that you can get even fatal poisoning by using too much of it, but it is not true that a patient has to have intermissions in his digitalis treatment. To stop digitalis for a time and start it again is a confession of failure. It means that the dose was not right; the patient was being given too much, and so it has to be stopped and started again and some of its advantages have been lost. If you get the right dose, then a patient can take it every day for ten years without any question of poisoning arising. Therefore, although the cumulative action of digitalis is real in the sense that it takes a long time for any particular dose to have its maximum effect, it does not mean that poisoning automatically occurs just because you keep a patient on a dose regularly.

INITIAL CONTROL WITH DIGITALIS.—MASSIVE DIGITALIZATION AND SLOWER METHODS.

Coming to the beginning of treatment of a patient who turns up with fibrillation, and who has to be got under digitalis control, the amount needed to get the patient digitalised can be worked out according to body weight. It is two and a half minims for each pound of body weight. Thus a man who weighs 140 pounds will require 350 minims, which is about 6 drachms. The patient will begin to show satisfactory digitalization when you have given him 6 drachms more than he has excreted. If you gave him 6 drachms straight away in one dose he would get under the influence of digitalis quickly, but that would be dangerous, because there is a good deal of variation in different patients. The ordinary answer to that has been to split it up into four doses, giving during the first day, to start with, 3 drachms, then 1½, and then ¾ and ¾ drachm, making 6 drachms, and, of course, if he showed satisfactory results, remembering the words I quoted from Withering, continuing until some of these signs appear, whether the good signs you want or the bad signs you do not want. That is what is called massive digitalization. It was a very popular method, more so in America than here, during the period between the two wars, but it has considerable dangers as well as advantages, and I think it has been misused.

By another method about two-thirds of this dose is given, but it is continued for the second day. A drachm is given for the first dose, and then three 30-minim doses are given, and this procedure is repeated on the second day, so that in two days you get the same total. A still safer method, but not one that works so quickly, is to spread it out over four days, giving half a drachm four times a day, making a total of 8 drachms. Supposing he excretes half a drachm a day you will have got your balance of 6 drachms to make the effective dosage.

Finally, a common method which is used in cases where there is no urgency about it—cases in which the patient is not really dangerously ill—is to give a perfectly safe dose, not much above the maintenance dose, and if that is continued for about ten days, giving a total of 10 drachms, during which he will have excreted about 5 drachms, you get somewhere near the proper dosage. Therefore, according to the urgency of the case, you can make use of something between massive digitalization which works in a day and a slow method which works in ten days.

Here I show a curve illustrating the pulse rate. You will observe that there is no effect for three or four days. The real effect begins somewhere around the seven- to ten-day period. Adequate digitalisation is produced. If the patient is not dangerously ill, and you have no anxiety as to how he is going to get on for a week, I think the method of slow digitalization is the safest and best. When you are acting as house physicians you will be tempted to do something more dramatic, because you will like to see quick results. But this method is without risk, it is more comfortable for the patient and, provided he is not unduly distressed by the fibrillation, I think the relatively slow method is to be preferred.

RAPID CONTROL WITH DIGOXIN.

I want now to speak about one form of digitalis which has certain special properties and works very much more quickly than these others. It is absorbed more quickly and excreted readily, and therefore there is less cumulative action and less difference between the amount you want to give to get the patient fully digitalised and the amount that you need for maintenance. The preparation in question is digoxin. The chart I show you illustrates the effect of giving digoxin by the mouth, and you will see that instead of taking seven days or so the process is complete in seven hours, and, indeed, is having some effect in two or three hours. It consists in giving 1.5 mg. of digoxin by mouth. The digoxin figure which I should like you to remember in comparison with the 15 minims of tincture, which I have taken as the average dose, is 0.25 mg. In other words, the average maintenance dose for a patient on digoxin is a quarter of a milligram three times a day. The average maintenance dose with tincture of digitalis is three-quarters of a drachm daily, and the amount needed to get the patient under adequate control is 6 drachms, which is eight times as much as the maintenance dose just mentioned. Here there is a much closer relationship between the maintenance dose and the dose originally given; the maintenance dose is 0.75 mg. daily, and it is necessary to give only twice that dose to get the immediate digitalisation. Digoxin is a much more potent extract, which works quickly and is better absorbed, thus giving its effect much sooner.

When I was a student a patient who came in seriously ill with fibrillation was often treated with strophanthin. Digitalis was the main standby for normal use, but because of the slow effect of digitalis the patient was given strophanthin intravenously when a quick effect was wanted. Digoxin has now replaced strophanthin in clinical medicine. Strophanthin is a drug of the digitalis group, and there are many others—extract of lily-of-the-valley is another—but none of them are as satisfactory as digitalis. With these others the toxic dose is so little less than the effective clinical dose that good results can rarely be obtained without some unpleasant toxic effects as well. Sometimes the dose that produces toxic symptoms is actually less than the dose which produces effective control, and therefore you can never get your adequate slow rate unless the patient has constant nausea. With digitalis there is a bigger margin—generally a comfortable margin—within which you can get all the clinical results you want before the patient begins to show any signs of overdose. Even quicker results can be obtained by giving digoxin intravenously.

The actual amount used in the cases shown on the screen is rather less than 1 mg. The safe dose for intravenous injection is 0.75 mg. I think the 1 mg. dose is for you to use when you consider yourselves fairly expert having had a good deal of experience in using it, while 0.75 mg. is a safe intravenous dose for those who have not yet had much experience. This will produce the same good effects as the massive digitalization produced in twenty-four hours or the slow digitalization in about a week or ten days.

OVERDOSAGE WITH DIGITALIS AND SOME GENERAL CONSIDERATIONS.

The next thing I want to bring to your attention is the effect as seen on the electrocardiogram. The first shows the tracing obtained with an untreated case of fibrillation and the effect of the administration of digitalis. The inverted T waves are fairly significant of digitalis action. It is a very odd thing that the drug which i ost

effective in treating cardiac failure should also produce these T wave changes. It shows how little we understand about the theory of the electrocardiogram and that our deductions are still empirical ones. The T wave inversion is certainly not a sign of over-dosage. When a patient begins to get coupled beats such as are shown in the next tracings, it is a sign that digitalis should be stopped for a time and restarted with a slightly smaller dose, because the next thing that may happen after digitalis coupling is paroxysmal tachycardia or even ventricular fibrillation.

Digitalis coupling, which is the only sign of over-dosage I have mentioned so far, is not, as a rule, the first thing. You will generally get an indication from the patient's symptoms first, and I think that nausea as a rule is the earliest indication. If the administration is continued too long after nausea there will be vomiting. One very important practical point arises here. The patient often vomits because of his heart failure. Just as you are familiar with œdema of the legs and congestion of the base of the lungs and congested liver, so the mucous membrane of the stomach is often congested and swollen, and that makes nausea and vomiting come very easily. You will quite often find that a patient has been started on digitalis and is vomiting; the doctor stops the drug because he thinks this is the first sign of digitalis poisoning, whereas it is really a sign of heart failure.

If a patient is vomiting with a heart rate of over 100 it is likely that the vomiting is still due to his heart failure and that he wants more digitalis. As a rule the heart rate will have got down to something in the neighbourhood of 60 or 70 before the patient begins to feel nausea and vomiting. I think that is a point we should watch for more carefully when giving digitalis, because it is generally the earliest sign that we are getting near the effective dose.

Often we see a patient thoroughly well digitalized; he is treated just as he should be, and the heart rate gets slow, but then, either because of the slowing rate or because of vomiting the digitalis is stopped. The patient may remain just as well for a considerable time—certainly for a week, sometimes for several weeks—so that it is thought that the digitalis has cured his fibrillation. But after an interval of weeks his heart rate quickens up again, and he will be just as bad as he was before. If you let him go out of hospital in that state he may well feel that only temporary good has been done to him. My rule, in peace-time, is that no patient leaves the hospital if there has been any change of dosage during the last ten days. If you have been giving the patient full doses of digitalis for several weeks and he has got fully saturated with it and can only excrete about half a drachm a day, the cessation of the drug will make very little difference to the total amount in the body for a considerable time, and therefore he will still remain quite well digitalized. This sometimes leads to the doctor as well as the patient failing to realise the need for continued digitalization. I am sorry to admit that I have patients of whom I am more sure that they are getting adequate treatment by their adjustment of their dosage to their needs, communicating with me perhaps once in two or three months, than by seeing their doctors regularly, if their doctors are too frightened of long-continued digitalis.

There is too much fear of over-digitalization. You will always find patients being put off digitalis and left off it until they relapse and have to be got under control again. Often I am ready to accept the patient's view that they want a little more or a little less digitalis. Your aim should be to get the patient to understand what is happening with digitalis so that he is able to help you as regards dosage, and quite often when the medicine is repeated patients will say that they would like a little more or less. So far from feeling insulted at a suggestion from them about their treatment, I nearly always accede to it at once, if they are intelligent patients whom I have been treating for some time.

What they mean by saying they want more is that they are having enough when resting, but if they have a little more they can take more exercise and do more and still keep their control rate. Digitalis differs in another way from many drugs where the object is to give the smallest possible dose to get an adequate effect. That is not true of digitalis. The patient is often at his best with the largest dose you can get him to take without unpleasant symptoms, and a dose which appears to produce quite a good control rate in the ward does not give him the maximum help when he is up and about.

That is most of what I wanted to say about digitalis in fibrillation. If you have a patient with normal rhythm, all the rules about treatment with digitalis are the same, but you cannot be nearly so sure that you are going to get a good effect, and although digitalis probably works by strengthening the beat of the heart as well as in

other ways, it is not so effective as with heart failure in fibrillation. Nevertheless, it is worth trying in heart failure of almost all types. The only exceptions are in the case of patients with thyrotoxicosis or active infection. Sometimes the stimulus of the rapid rate of fibrillation from their diseased thyroid seems to override the good effects of digitalis, and you cannot be sure that you are going to get the slowing of which I have spoken. In all other cases, if you do not get slowing, you should make certain that the patient is taking the drug or that the sample of digitalis you are giving is an active one.

Although slowing of the rate in fibrillation is a fundamental part of its action and the best test, it has no place whatever in slowing other forms of tachycardia, whether due to toxic or nervous causes. Tachycardia is not in any way an indication for digitalis treatment. The indication is heart failure, and the double indication is heart failure with auricular fibrillation.

Keats' Anniversary

GUY'S TO KEATS

ON THE 150TH ANNIVERSARY OF HIS BIRTHDAY, OCTOBER 31ST, 1795.

"'BEAUTY is truth, truth beauty'—that is all"
Echoes the burden of your melody,
Who left these gates of healing at the call
To build a song-filled shrine to Poetry.
Surely within those viewless walls there lies
A thought for this old house of charity,
Where once you learnt to watch Truth's tranquil eyes,
And murmur "*Dare Quam Accipere*"?
Let but one phantom-memory of Guy's
Linger for ever there! Beguiling thought
That teases, holding out a richer prize
Than all that golden guineas ever bought!
My dream dissolves, as hushed o'er hill and dale
The liquid music of your nightingale.

E. A. PENNY.

TO KEATS, POET OF TRUTH AND BEAUTY

Hadst thou not sung
Dawn would have lacked its first faint herald flush,
Sunset its valedictory after-blush,
And darkling eventide its deepest hush.

The jewelled canopy of velvet night,
Unsing by thee, had shone less silver-bright
As though each star sank back and dimmed its light.

The tree-clad mountains and the vales between,
The forest glades, the panoramic scene
Had lost some lustre of the living green.

Sweet peas had never tiptoed for a flight,
No loaded brush had dyed the rose more bright
Or touched with radiance the lily's white.

The bloom upon the grape were less intense,
Nor would the breath of violets flood the sense
But for a moment, e'er it faded hence.

Gone were thy Knight at arms so wan and pale!
Gone the rapt utterance of thy Nightingale!
Gone the new vesture for the old Attic tale!

No Grecian Urn with pastoral overwrought
Had pleaded "Truth is beauty," or had taught
"All knowledge lies herein—the rest is naught."

Eternal Rome had never known thy face,
Nor, when too soon thy dust demanded space,
Would she have drawn it to her long embrace.

And Adonais from sad Shelley's pen
Had never flowed to stir the hearts of men
Sighing for thy drooped head, to-day as then.

But now all Nature wears a richer dress,
And Beauty passes through no dim recess
To wander in the wastes of nothingness—
For thou has sung ! E. A. PENNY.

Correspondence

GUY'S STUDENTS' UNION.

To the Editor of the GAZETTE.

SIR,—In a recent issue of the *Gazette* I described the Guy's Hospital Students' Union as being unaffiliated to the Clubs' Union. In this I am in error ; the Guy's Hospital Students' Union was, in fact, affiliated to the Clubs' Union in July, 1943.

I am, etc.,
F. R. KILPATRICK,
Hon. Sec., Guy's Hospital Clubs' Union.

Guy's Hospital, S.E.1.

INTER-HOSPITAL VISITS.

To the Editor of the GAZETTE.

SIR,—We read with interest your editorial in the current issue of the *Gazette*. Your suggested scheme for inter-hospital visits is very similar to that the B.M.S.A. attempted to arrange recently, without success. Only two of the London hospitals were prepared to allow outside students into their already crowded departments. One of these—"The London"—offered an open invitation to other hospitals to attend any teaching at any time, but their offer did not apply to women students. This excluded two hospitals completely, and those which are mixed were not inclined to accept the invitation on behalf of their men only.

A letter to us from Mr. Ian Munro on February 12th of this year said that he had met the Medical School Council and was informed that there were so many students at Guy's already that they could not cope with even occasional visits from outside students.

One hospital said that it was an insult to imply that their students could obtain better teaching by visiting others. I feel that your suggestions are not likely to be adopted until a less restricted attitude to medical teaching is adopted by the authorities of the London hospitals; I might add that inter-hospital visits have been successfully arranged on several occasions in the provinces, with excellent co-operation from the staffs.

I am, etc.,
JOHN RICH,
President, B.M.S.A.

British Medical Students' Association,
B.M.A. House, Tavistock Square, W.C.1.

Sport

Rugby

GUY'S *v.* NUNEATON.
(*Played on Saturday, September 29th.*)
Won 19–7.

Throughout this game intermittent periods of scrappy play marred some very fine movements, and hard though the ground was, low tackling and first-time heeling was seen on too rare occasions. In the set scrums the ball was evenly shared, as was much of the play between two well-matched packs. The Guy's three-quarters outclassed their opponents and thus won the game. From the play it was obvious that the forwards must endeavour to ensure a speedier service of the ball to their back division, whether from the scrum, the maul, or the line-out.

D. G. Jones opened the scoring for Guy's with a neat penalty goal. This was followed by two goals—one dropped and one penalty—for Nuneaton, putting them ahead. Nuneaton

played well at this stage of the game, but failed to cross the Guy's line.

The next score for Guy's was a try by P. van de Westhuizen. Jones snapped up the ball from a floating pass made by his opposite number and made the opening for the try under the posts. Billingham kicked the goal.

Billingham continued the good work when, early in the second half, he landed a penalty. The remainder of the game was dominated by the Guy's three-quarters, who really showed their paces. Two excellent passing movements resulted in tries by N. K. Macrae-Gibson, who used all his skill and swerve to cap two first-class movements. Billingham converted the second try.

GUY'S *v.* UNITED SERVICES (PORTSMOUTH).

(*Played on Saturday, October 6th.*)

Lost 0–6.

On a fine sunny afternoon Guy's took the field intent on putting up a good performance before the large crowd assembled to see the first United Services game for six years.

Playing into a bright sun Guy's went away to a good start, and several times during the first quarter of an hour, the ball travelled neatly along the three-quarter line without gaining much ground. At this period of the game especially, F. le Clus was handling the ball beautifully, taking all and every pass at good speed.

The first score came as a break away from mid-field, when a United Services three-quarter slipped inside his man and sent S. Peel away for a try under the posts. D. G. Jones charged down the kick at goal. For the remainder of the first half Guy's held their own without having complete control of the play.

In the second half Guy's were consistently on the defensive, and although Keeling hooked the ball from almost every scrum, the heeling in the loose was by no means good, and seconds wasted at the base of the scrum prevented Jones and Westhuizen from making openings before being tackled. Near the end of the game G. N. Jones, having been well tackled twice by Gray and Keeling, fell over the line to give United Services their second try.

Throughout the game the wings had little opportunity of showing their worth in attack, but defended consistently well. McCallum and Eksteen worked hard in a much improved pack.

GUY'S *v.* OLD MERCHANT TAYLORS.

(*Played at H.O.P. on October 13th.*)

Won 42–0.

Guy's defeated Old Merchant Taylors by six goals and four tries (42 points) to nil.

It was good to see the 1st XV scoring freely after last season's reverses. Our strength now lies in the three-quarters, who showed us in their game that they possessed great thrust in attack. Admittedly the opposition's defence was not good, but our clean handling of the ball and the clever movements and combinations were beautiful to watch.

D. Le Clus took M. Gray's place vacated through injury at full-back and played a good game. Our half-back problem was solved by reappearance of R. Vann at scrum-half after a season's absence; he quickly got to know F. Le Clus at fly-half and maintained a good service from the scrum. F. Le Clus handled the ball cleverly and fed the three-quarters an excellent stream of well-timed passes.

In the three-quarters high praise must go to all for an excellent performance. F. G. Jones and P. Van de Westhuizen, the centres, gave us a polished display of Rugby, both working well with their wings. Van de Westhuizen was good to watch with his tricky tactics and a keen eye for an opportunity. Jones delighted us with his reliability and faultless kicking. The wings, N. Macrae-Gibson and P. J. Dwyer, played well, the former making great speed in attack and being his reliable self in defence.

In this orgy of scoring it is difficult to pick out tries, but I think the first, by Macrae-Gibson, was one of the best he has ever scored; running at great speed from the ten-yard line he swerved beautifully past three men to touch down. And the last try by Van de Westhuizen was great to watch. He intercepted a pass on our "25" and ran the length of the field hotly pursued to touch down near the posts.

Tries were scored by Macrae-Gibson (two), Van de Westhuizen (two), and one each for Hilliam, Jones, Dwyer, MacCallum, Carton-Kelly and Hatton. Van de Westhuizen kicked four goals and Jobes two.

Of the forwards Keeling, Hatton and De Villiers showed great promise, and all the old hands played well. Dare I add a little criticism? I believe it would be possible to get a little more out of line-outs and loose scrums.

SEASON 1945–46—FIXTURES

FIRST XV.

Date	*Ground*	*Opponents*
1945.		
Nov. 3.	H.O.P.	Old Blues
„ 10.	Teddington	St. Mary's
„ 17.	H.O.P.	Rosslyn Park
„ 24.	Devonport	Devonport Services
Dec. 1.	H.O.P.	Coventry
„ 5.	Oxford	Oxford Univ.
„ 8.	—	—
„ 15.	Sudbury	Wasps
„ 22.	H.O.P.	R.N.E.C., Devonport
„ 29.	—	—
1946.		
Jan. 5.	Blackheath	Blackheath/Richmond
„ 12.	Twickenham	Harlequins
„ 19.	H.O.P.	Old Alleynians
„ 26.	Old Deer Park	Rosslyn Park
Feb. 2.	Coventry	Coventry
„ 6.	Cambridge	Cambridge Univ.
„ 9.	H.O.P.	Wasps
„ 16.	South Croydon	Old Whitgiftians
„ 23.	—	—
Mar. 2.	Herne Hill	London Welsh
„ 9.	H.O.P.	Bedford
„ 16.	H.O.P.	Metropolitan Police
„ 23.	Gloucester	Gloucester
„ 30.	H.O.P.	Rotol, Gloucester
Apr. 6.	H.O.P.	London Irish

Association

GUY'S *v.* OLD FINCHLEIANS.

(*Played at H.O.P. on September 29th.*)

Result: Draw 2–2.

The standard of football reached in this, our first game of the season, was not all that one might have expected. The Guy's team produced many fine individual efforts, but failed to co-ordinate its movements.

Early in the first half Guy's took the lead. From a bunch of players near our opponents' corner-flag, the ball went to R. K. Foster. He immediately passed the ball cross to I. A. H. Munro, who had moved in from the outside right position. Munro was well positioned and had little difficulty in scoring. A few minutes later Guy's nearly increased their lead, when Foster, having intercepted a loose ball, hit the crossbar with a hard drive from thirty yards. At half-time the score was 1–1.

Owing to a misunderstanding in our defence the Old Finchleians scored again early in the second half. Guy's pressed hard, but were not rewarded until A. E. Trist, whilst harassing the opposing goalkeeper, caused the ball to

be dropped. Trist quickly took the opportunity and shot the ball into the net.

Both teams tried hard to force another goal, but the score was still unchanged at the final whistle.

Team.—E. J. Deutsh; D. Sheerboom, R. A. C. Dove; E. M. Newton; H. R. C. Riches, C. S. Matthews; I. A. H. Munro, M. J. L. Sykes (captain), A. E. Trist, R. K. Foster, R. W. Nicholls.

GUY'S *v.* ROYAL MARINES (CHATHAM).

(*Played at H.O.P., Saturday, October 6th*).

Result: Lost 4–2.

It was expected that this match with the Royal Marines would be one of our hardest games of the season. Our expectations became reality when play began. From the very start the Marines attacked, and although the ball was repeatedly cleared from the Guy's goal area, it returned with embarrassing regularity. As play progressed the game became more midfield, with occasional attacks by either side.

The first goal was scored by A. R. Merrill for Guy's after twenty-five minutes' play. Merrill, from the outside-left position, centred into the goal-mouth. The ball, which was spinning violently, completely beat the goalkeeper and ended in the far corner of the net. This success stimulated the Guy's team to even greater effort, but there was no further score by half-time.

For the first twenty minutes of the second half Guy's still kept their one goal lead. Quite suddenly, however, the position was completely reversed. In a matter of six minutes the Marines scored four goals! Guy's played hard to stave off defeat and when R. K. Foster scored ten minutes from time, it seemed just possible that the game might still be saved. However, there were no further goals scored and the Marines finished worthy winners of a hard and enjoyable game. Of the Guy's team, R. A. C. Dove and J. Deutsh gave very creditable performances and deserve special mention.

Team.—J. Deutsh; A. W. R. Williamson, R. A. C. Dove; E. M. Newton, H. R. C. Riches, C. S. Matthews; I. A. H. Munro, M. J. L. Sykes (captain), A. E. Trist, R. K. Foster, A. R. Merrill.

Hospital Information, etc.

Notice

GUY'S HOSPITAL DENTAL SCHOOL (UNIVERSITY OF LONDON).

Applications are invited for the post of Demonstrator in Operative Dental Surgery. Attendance a minimum of three sessions per week, honorarium at the rate of £60 per annum per session.

Hours: 9.0 a.m. to 1.0 p.m. or 2.0 p.m. to 5 p.m.

The appointments are subject to annual re-election, and in this instance will be made for the period terminating 30th September, 1946. Candidates, who must possess a registrable qualification, should forward their application not later than 10th November, 1945, to the Dean, Guy's Hospital Medical and Dental Schools, London Bridge, S.E.1.

The Services

AWARDS.

M.C.

Major (Temp.) F. I. Evans, R.A.M.C.

O.B.E. (Military).

Lt.-Col. R. T. Grant, R.A.M.C.

M.B.E. (Military).

Major E. R. R. Mellon, R.A.M.C.

Mentioned in Dispatches.

In recognition of gallant and distinguished services in Burma:—

Lt.-Col. (Temp.) H. J. Croot, R.A.M.C.

Capt. H. A. Kreiser, R.A.M.C.

Papers by Guy's Men

Plummer, N. S. The treatment of the chronic tuberculous patient. *Med. Pr. & Circ.*, 1945, **214**, 198.

Behrman, S. Acroparæsthesia. (A Summary.) *Proc. Roy. Soc. Med.*, 1945, **38**, 600.

Clarkson, Patrick, and Another. Treatment of denuded external table of the skull. *Brit. Med. J.*, 1945, ii, 422.

Ogilvie, W. H., and Others. Arterial Aneurysm following injury to iliac vessels. Report of two cases, with a commentary on large transfusions. *Brit. Med. J.*, 1945, ii, 451.

Leader, S. A. Acrylics in conservative prosthetic Dentistry. *Dental Rec.*, 1945, **65**, 217.

Crisp, E. J. Damaged intervertebral disk: early diagnosis and treatment. *Lancet*, 1945, ii, 422.

MacFarlane, D. W. The stiffness of toothbrushes. *Brit. Dent. J.*, 1945, **79**, 179.

Leader, S. A. Research and in acrylics. *Ibid.*, 183.

Hallam, J. W. A new method of interdental wiring. *Ibid.*, 189.

Harkness, A. H. The cutaneous manifestations of gonorrhœa. *Brit. J. Ven. Dis.*, 1945, **21**, 93.

Witts, L. J. Diseases of the liver. *Practitioner*, 1945, **100**, 205.

Houghton, L. E. Pulmonary tuberculosis. *Ibid.*, 233.

Denny-Brown, D., and Another. Changes in the Nervous system in acute porphyris. *Brain*, 1945, **68**, 1.

Blomfield, L. B. Intramuscular vascular patterns in man. *Proc. Roy. Soc. Med.*, 1945, **38**, 617.

Bankart, A. S. B. A case of pathological dislocation of the hip—and what happened to an epiphyseal transplant. *Ibid.*, 618.

Marriages

BARKWORTH—WRIGHT.—On September 15th, 1945, at Herne Hill Baptist Church, F. R. S. Barkworth, M.B., B.S., to Beryl N. Wright, S.R.N.

BRONSDON—MIZEN.—On September 26th, 1945, at St. Luke's Church, Maidenhead, Noel Bronsdon, F O (D.), R.A.F., of Eltham Kent, to Joan Mizen, of Maidenhead, Berks

BRIGHT—BALDWIN.—On October 1st, 1945, at Delhi, India, Marette ("Jane") Baldwin, Q.A.I.M.N.S.R., to Major Kenneth Bright, Royal Scots Fusiliers.

Deaths

LOWDELL.—On October 6th, 1945, at 14, Edensor Road, Eastbourne, Charles George Walton, late Lieut.-Col., I.M.S.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1495 *10th November, 1945* *Ninepence*

PASSIM

IT is with profound regret that we announce the death of Dr. R. D. Gillespie. The news of his passing has come as a great shock to us all here at Guy's, and the Hospital has sustained a great loss from which it will not easily recover. The unfailing energy and drive which he devoted to his work and the quiet dignity which was so much a part of the man himself were qualities which never failed to impress all those with whom he came into contact. He was a regular contributor to the *Gazette*, and we are proud to reflect that the last clinical lecture he delivered at Guy's was published recently in these pages. Ours is not the pen to write a full appreciation of Dr. Gillespie's life and work, a task which should fall to others far more suited than ourselves. We do, however, wish to express our own sincere sorrow and our sympathy to his wife in her great loss.

MANY readers will have heard the broadcast appeal given recently by Matron on behalf of the Hospital. The response to the appeal has so far been quite satisfactory. Donations are still arriving and the sum total so far achieved is approaching £4,000.

WE are pleased to welcome back Lieut.-Col. E. H. Rink from the Army. Brigadier Grant Massie is also back, and we hope that he will soon resume his teaching duties at the Hospital.

WE publish in this issue reports on the Sailing, Music, and Athletics Clubs; these were unable to be included along with the other club notices in the *Gazette* issued on October 13th, 1945, owing to lack of space.

"WHAT has happened to Guy's rugger?" How often, last season, did we hear this question asked, and how difficult was it to find a suitable answer to account for the series of disappointments that made up last season's fixture-list. Ask the same question this season—and, in framing it, substitute for a tone of regret one of pleased curiosity—and the suitable answers are not so difficult to find.

Perhaps our surprise success against St. Mary's Hospital in March of this year ended the chapter of disaster with a promise of good things to come. And most certainly they have come; not in the form of a series of overwhelming victories—the season is still young—but in the re-awakening of enthusiasm clearly shown in every member of the Hospital, be he player, spectator, or neither. As to the player, the introduction into the team of new blood has produced play of a higher standard. As to the spectator, the repeated demonstrations of enthusiasm seen on the touch-line on every match day this season have, as any member of the team will testify, a very beneficial moral effect upon those on the field.

Nor is this atmosphere of vitality confined to the sphere of rugger alone. It is to be found just as surely in the Hospital itself, where the return of more of the teaching staff has produced in the student an increase in thought and activity. Four surgical firms now replace the three that we knew during the War years. Lydia and Queen wards are open again. The main theatres in Guy's House now flourish once more.

The same enthusiasm is reflected in the optismistic club reports concerning their present and future activities which have been published in the *Gazette*. Such an attitude, present as it is in all spheres of hospital life, is excellent and to be encouraged. Let us hope that progress continues, leaving no room for retrogression.

Congenital Syphilis in the Infant

By V. E. LLOYD, M.C., M.B., B.S.

SYPHILIS, as you are aware, may be transmitted from mother to child, an event that, fortunately, is considerably less frequent at the present day than in former times. The infection of the unborn infant follows on the entrance of the syphilis spirochaete into the fœtal circulation, a transference which does not take place before the formation of the transplacental circulation in the fifth month of the life of the fœtus. Whether or not syphilitic infection will develop in every fœtus to which spirochaetes gain access is unknown, but presumably the incidence of infection is high. However, we are certain that on some occasions a healthy child may be born of a syphilitic mother, and, moreover, that her subsequent and younger infants may yet be syphilitic. It is clear that the transmission of syphilis from mother to child is not inevitable and, in fact, it is well known to be variable.

The transmission of the disease is much more frequent when the mother is suffering from syphilis in its early active stages—primary or secondary stage. When pregnancy occurs during the late stage of syphilis such transmission may be irregular or even cease, so that when the disease is quiescent or latent in the mother the infant may escape infection. When a woman is infected early in marriage her first child is likely to be severely diseased. In subsequent pregnancies the affection of the infant may be less severe. As a broad and general rule the fate of multiple pregnancies in a syphilitic woman is as follows :—

1. Premature still-born syphilitic infant.
2. Living syphilitic infant, usually premature, who dies shortly after birth.
3. Apparently healthy infant showing signs of syphilis within a few months.
4. Apparently healthy infant who suffers from syphilis in later childhood or adolescence.
5. A child who remains in good health but has a positive Wassermann reaction all through into adult life and possibly until death.
6. A healthy child who shows and develops no physical or serological signs of syphilis.

This sequence, I would remind you, is a broad outline only and is subject to variations and inconsistencies. (Modern statistical enquiries do not uphold the former teaching that natural abortions are particularly frequent in syphilitic women. Apparently they have abortions just as often as other women do—no more and no less.)

We sometimes see a family in which only one or two children are affected, usually to a mild degree, whereas the remaining children, some older and some younger, are free from disease. This inconsistency has been observed for very many years, and is now accepted as an indication of the variation of activity of the infection—*i.e.*, of the degree of latency of the disease—in the mother. During the torpid phases the fœtus will escape infection, but in later pregnancies, during which the mother's infection may become more active, the disease may be transmitted to the fœtus.

Abraham Colles, the famous Dublin surgeon, who, by the way, was a particular friend of Astley Cooper, and who assisted him here at Guy's in the dissections from which were executed the engravings in Astley Cooper's works on the anatomy of hernia, made important statements concerning the natural course of syphilis in mother and child. His remarks, since termed "Colles' law" by Jonathan Hutchinson and later by many others, are as follows :—

> "I have never seen or heard of a single instance in which a syphilitic infant (although its mouth be ulcerated) suckled by its own mother had produced ulceration of her breasts; whereas very few instances have occurred where a syphilitic infant had not infected a hired wet nurse and who had been previously **in good health.**"

In Colles' day it was not realised that all these mothers were affected with syphilis and were exhibiting a resistance to further infection (superinfection) with syphilis. At this time there was much talk of the paternal transmission of syphilis from spermatozoon directly to ovum and thence to fœtus without infection of the mother. Now we are aware that the Wassermann and other serological tests for syphilis are

positive on the blood of almost all these mothers. Colles' statement is still true and his observation serves to remind us of the apparent complete latency (freedom from syphilitic lesions) in many infected women during the child-bearing period, although they may produce severely affected syphilitic infants.

This latency or torpidity of syphilis in the mothers of syphilitic infants is apparently a complete suppression of the various cutaneous rashes which may take place in the secondary stage, and doubtless accounts satisfactorily for the complete absence of any history of the early manifestations of the disease in their replies to detailed and skilled interrogation. This latency has also been encountered in experimental work with syphilis. When female rabbits were infected with *S. pallida* those which were pregnant at the time of inoculation or shortly afterwards showed either no lesions or far less severe lesions than the non-pregnant rabbits.

SYPHILIS IN THE STILL-BORN CHILD.

Maceration of the still-born child has long been regarded as almost diagnostic of syphilis; but, while it is undoubtedly suggestive, this state is not pathognomonic and may be the result of other intoxications. The skull of the dead fœtus is collapsed, the abdomen protuberant and the skin appears as if scalded, the epidermis showing extensive bullæ which are easily rubbed off to reveal the livid red colour of the cutis. Syphilis has been found in macerated still-births in a proportion varying from 25 to 64 per cent. in different series. The tissues, more particularly the viscera (lungs, liver, spleen) of the macerated fœtus are usually teeming with spirochaetes, but from the enormous number present it seems likely that they must multiply considerably after the death of the fœtus and whilst it is still *in utero*.

SYPHILIS IN THE NEWLY-BORN INFANT.

Congenital syphilis is a blood-borne infection. The transmission of syphilis from mother to fœtus is a process similar to the occasional accidental transmission of syphilis by therapeutic blood transfusion. There is therefore no sign of an external primary lesion—infection is generalised from the commencement. Chancres, however, are occasionally seen in young infants—*e.g.*, on the face or scalp—from infection taking place during the journey through the ulcerated maternal genital passage, These are usually multiple, but in other characters are similar to the chancre from syphilis acquired in older children or in adults.

The infected newly-born infant rarely bears any external sign of disease. Exceptionally, the syphilitic baby may show at birth crops of small bullæ surrounded by a brown halo situated on the palms or soles. This condition, termed "syphilitic pemphigus," may spread rapidly to the limbs and trunk. It may be especially extensive in the napkin area where the epithelial covering of the bullæ becomes rubbed off; secondary bacterial infection is then frequent and the condition simulates pemphigus neonatorum. These bullæ are seen only in emaciated and severely diseased infants who usually die within a week or so.

In general, the infant is usually healthy in appearance at birth, but within a few weeks suffers from nasal catarrh. Its breathing is noticed to be snuffling and its upper lip and nostrils become sore from the irritation of the nasal discharge which is often hæmorrhagic. About the same time a rash appears on the face, trunk, limbs, buttocks and genital organs. The infant's cry becomes hoarse, probably from affection of the larynx; the spleen and liver becomes slightly enlarged. The child's nutrition is usually affected partly from the difficulty in feeding produced by the snuffles and nasal obstruction. The skin becomes dry, assumes a dirty light brown tint and is wrinkled when wasting is marked.

CUTANEOUS MANIFESTATIONS.

With the exception of syphilitic pemphigus, which may be present at birth, the cutaneous lesions of syphilis are usually delayed until the infant is from three to eight weeks old. The rash most frequently consists of scattered dull red macules or papules similar to those seen in the secondary state of the disease in adults, but although widely distributed the rash in the infant is less profuse. The papules are situated chiefly in close proximity to mucocutaneous junctions such as around the mouth and nose, also on the forehead, on the palms and soles and on the buttocks. In the latter region as well as in the groins, particularly in fat infants, the papules merge into extensive slightly raised patches which remain dry, shiny and inelastic, and which have the colour of lean ham. These papules may be present for many weeks during which

period they thicken but do not ulcerate, except occasionally at the flexures, and they slowly alter in hue from their initial red colour to that of lean ham; if persistent over many weeks they develop a coppery or even a mahogany colour.

Desquamation is a common feature of these lesions and in some infants areas of skin which are only slightly reddened and thickened may peel off. This peeling is most frequently seen on the palms and soles and it sometimes occurs at these sites in the absence of other cutaneous lesion.

Indurated angry red patches and erosions are not infrequently found around the mouth and nostrils, more particularly when syphilitic rhinitis giving rise to snuffles is present. These are partly due to the irritating and constant effect of the sanguineous nasal discharge. Fissures in the skin are apt to occur at the angles of the mouth and below the centre of the lower lip; secondary bacterial infection of these fissures delays healing and eventually radiating linear scars are produced (rhagades), which remain permanently as one of the stigmata of congenital syphilis.

The superficial patches of white sodden desquamating epithelium concealing erosions on the inner surface of the lips, fauces, gums and cheeks, which may be seen at the same time as the rash, are comparable to the so-called "mucous patches" of the secondary stage in the adult; and, as in the adult, their infectivity is of high degree because of the very numerous spirochaetes present in the secretions. In some infants thick moist papules form around the anus—syphilitic condylomata; they are occasionally seen at the angles of the mouth. These are also highly infective. Vesicles, pustules or crusted lesions are not common; they are sometimes seen mingled with the papules, thus illustrating the polymorphic character of syphilitic eruptions.

During the period of the rash there may be moderate enlargement of the lymphatic glands; these remain indolent and do not suppurate. If the infant is plump and of a healthy appearance, which it well may be when the rash first appears, the general nutrition soon deteriorates, and anæmia is often marked. The hair becomes thinned and a patchy alopecia is noted which may affect the eyebrows and eyelashes. Both the liver and the spleen become enlarged, the latter very frequently.

AGE INCIDENCE OF THE MORE FREQUENT EARLY LESIONS.
(Jeans and Cooke, 1930.)

Month at which the lesions were first seen	*Rash*	*Rhinitis*	*Epiphysitis*	*Condylomata*	*Dactylitis*
0–1	23	21	5	1	–
1	122	97	37	4	2
2	104	92	25	3	2
3	52	59	11	4	2
4	19	22	2	2	3
5	14	22	2	1	2
6	8	10	–	–	–
7	7	12	–	2	–
8	4	8	–	–	–
9	4	5	–	3	–
10	1	2	–	2	–
11	1	4	–	2	–
12	1	5	–	1	–
12–18	3	5	–	6	–
Total	363	364	82	31	12

Bone Lesions.—These are frequent and may occur at any time during infancy. They have been found post-mortem and by X-ray examination in still-born infants and are probably present *in utero*. Apparent paresis of the infant's limb is caused by an acute epiphysitis termed "osteo-chondritis syphilitica," which attacks the end of the long bones, most frequently the humerus, radius, ulna and femur, and may cause separation of the epiphysis. A slightly tender swelling of the joint is produced and a variable degree of loss of power of the limb. When the lack of movement from disinclination is complete (Parrot's pseudo-paralysis) the condition may be mistaken for a birth injury to the brachial plexus (Erb-Duchenne type). Sub-acute or chronic periostitis of the shaft of the long bones is common at any age during infancy and may give rise to few clinical signs. X-ray examination is a most valuable method of diagnosis in congenital syphilis and may reveal unsuspected change in many of the bones. A relatively painless fusiform swelling of several of the phalanges or metacarpals (syphilitic dactylitis) may occur up to five years of age. In the skull there

may be hypertrophy of the spongy bone at the edges of the anterior fontanelle, which imparts to the infant's head a contour reminiscent of a hot-cross bun.

The syphilitic rhinitis of early infancy often leads to chronic infection of the nasal and other bones of the nasal cavity. Destruction of these bones or their arrested development causes, later in infancy, the well-known deformity known as saddle-nose, another of the hall-marks of congenital syphilis. There are no characteristic changes in the milk teeth; the diminutive notched incisors (Hutchinson's teeth) are seen only in the second dentition.

The part played by syphilis in producing idiocy and mental deficiency is uncertain; the experience of various authorities as to the proportion of mentally afflicted children who have syphilis varies from 6 to 39 per cent. Among the more rare conditions caused by syphilis in the infant are meningitis, hydrocephalus, choroiditis, iritis, epilepsy and orchitis. Interstitial keratitis, the commonest syphilitic lesion in childhood and adolescence, is rarely seen in the infant.

The Wassermann reaction in the infected infant is positive when tested a few weeks after birth; it is probably positive at birth, but is rarely done at that time. It is a common practice to have a Wassermann test done on the umbilical cord blood at birth, but a positive result at this time may be due to the presence of the reacting substance which has passed through to the fœtal blood from the mother; in such a case, if the infant has escaped the infection, its blood will give a negative result between three and six months later; if the child be infected the Wassermann reaction will remain positive or become more strongly positive.

Do not expect to find all the lesions I have described present at the same time in the infant. Frequently only one or another is present. And, finally, when you are visiting a sick infant concerning whom your suspicions of syphilis are aroused, do not omit to take a peep at the other children nor to ask if Father's health is good.

Correspondence

INTERNATIONAL STUDENT SERVICE.

To the Editor of the GAZETTE.

SIR,—May I, through the columns of the *Gazette*, ask for the support of Guy's men and women for the 1945–46 Appeal of International Student Service.

During the past year contact has been made with the universities in France, Belgium, Holland, Italy and Greece, and the first International Student Conference was held in Combloux, Haute Savoie, this July. This was followed by a meeting of the I.S.S. Executive in Geneva. The result has been the realisation of the desperate need not only for material relief, but for understanding and cultural co-operation.

The Western European countries are receiving books, drugs, clothes, X-ray apparatus for examining tubercular students, bedding for hostels, scholarships for destitute students. And it is hoped to extend these and similar services to Norway, Finland, Austria, Czechoslovakia, Yugoslavia, Poland and Hungary. In addition, certain special items must be mentioned:—

At Combloux, with the assistance of "Action Suisse pour les Etudiants Victimes de la Guerre," I.S.S. has set up a rehabilitation centre for French students, where they may recover after exhausting years in the Resistance or as prisoners and political deportees in Germany.

At Leysin, Switzerland, an International University Sanatorium for Tubercular Students has at last come into being and has already received sufferers from France, Belgium and Holland, and has now been opened for a number of tubercular British students. This sanatorium will cost £60,000 to run this year. Part of this sum will come from Donations Suisse pour les Victimes de la Guerre, but we must find the rest.

In England the I.S.S. has established a rest home for Dutch students at Ashton-Hayes, Chester, which will receive a group of from twenty-five to thirty students each month. After one month in the home the students should spend one or two months in private British homes. Numerous offers of hospitality have been received, but more would be welcome. This project, inspired by the Combloux model, will, it is hoped, be repeated in other countries.

Now this, which is by no means the whole of the work undertaken, needs money. In Great Britain, this year, we have to raise £100,000 towards the World Student Relief Budget, of which £20,000 *must come from London area.*

This is the *greatest opportunity we in this country have ever had to receive the* honour and affection of our fellow students by helping them in their dire need. This is also the greatest opportunity we have ever had to weld together the great seats of learning in the common ideals of culture, brotherhood and humanity embodied in the word "Universitas." Surely it is not necessary to impress this more on university people, but if it is then I would draw attention to the *comments* of the External Registrar at a recent meeting of the London University I.S.S. Committee, when he said that if we did not do everything in our power to help the students, and resuscitate the university life of the countries overrun by Germany, then the Nazis, whose fundamental aim was, after all, the destruction of Western culture, would have won the biological war even if they had lost the military one.

Monetary contributions will be gratefully received by myself and passed to the appropriate authorities. Gifts of clothes should be sent to: I.S.S., 21, Princes Gate, Knightsbridge, S.W.1. Books, and especially medical and dental journals which are urgently needed, should be sent to :—I.S.S., 1, Sloane Square, London, S.W.1.

Hoping that this appeal will meet with a generous response.

I am, etc.,

ROBERT C. GREENBERG,

Guy's Member London University I.S.S. Committee.

Guy's Hospital, S.E.1.

"PROSTHETIC DENTISTRY."

To the Editor of the GAZETTE.

SIR,—In reply to J. B. K.'s review of "Prosthetic Dentistry" by F. W. Cradock, in the *Guy's Gazette* of August 18th, 1945, may I be permitted to comment, firstly, on the statement "that the Face Bow for estimating the inclination of the condylar path is a frill, and more, an inaccurate frill which is better dispensed with."

The Face Bow was first demonstrated by Snow, an English dentist, in 1907, and it is, in the opinion of the most eminent prosthetists, the greatest advance in dental metrology since the birth of prosthetics. The Face Bow is *not* employed as your author states, "to estimate the inclination of the condylar path." This statement is grossly inaccurate. The face bow record has no more bearing on the condylar inclination than it has on the age of the patient or the colour of her eyes for that matter. It is employed to obtain two distinct and necessary functions :—

1. To obtain a three dimensional positional relation record of the maxilla to the kinematic condylar axis of the mandible in the rest position.

2. To incorporate into this record the resilient and like effects of all the tissues involved during the masticatory effort.

Omission to employ the Face Bow in complete denture prosthesis and, in particular, for difficult cases, is to court disaster. In order to establish balanced occlusion it is essential to mount the casts in the articulator in the exact relative position which is occupied by the edentulous maxillary and mandibular ridges of the individual patient.

Further, J. B. K. goes on to quote from the book :—"Probably no method of recording condyle path inclination is accurate to more than plus or minus 10 degrees." I cannot conceive how he obtains any registration of angle at all with the face bow. I would direct his attention to the method accepted by the leading American universities—namely, the "Hanau technique." I venture to suggest that J. B. K. would revise his views after he familiarises himself with this method.

To the comment that in the hands of the student, dentures made on a fixed or average articulator "seem no worse" than those made on articulators "smothered in estimated variables," I can but answer that those students must be taught variables, and tuition which omits or ignores them is inadequate.

Whereas I admit that there is a tendency to excessive complication of specialised

techniques, it must be realised that an equal if not greater danger exists—namely, that of over simplification of a problem. Such an attitude induces a false sense of security and inevitable mediocrity in prosthetic results.

I am, etc.,

40, Lister Buildings, Jeppe Street, Johannesburg. F. POPPER.

A SILENT REVOLUTION.

To the Editor of the GAZETTE.

SIR,—It would be impertinent to attempt to improve on Dr. Vertue's scholarly and sincere appreciation of Dr. Cameron's work at Guy's, but may I, as his first pædiatric H.P., make one or two addenda ?

The first children's ward, indeed, came into existence after the first German War, but the fertilised ovum had already obtained lodgement in a curious attic-like ward above Miriam, called the Baby Room, where, in spite of its location, some remarkably good work was done. Then Miriam itself was transformed from a ward full of old ladies dying from obscure complaints to a place where children got well. The children's ward was opened in the year of the Keats' centenary, and I remember that, as editor of the *Gazette*, I suggested commemorating Guy's great poet by naming the ward after him. The powers frowned on the idea then—perhaps because Keats' references to Guy's, in his " Ode to a Nightingale," were far from complimentary—but the project was resuscitated later.

One or two things in Dr. Vertue's article surprised me. I had not realised that the Borough had become such a health resort for children, with no infantile diarrhœa, feeding disorders, or pneumonia ! I am afraid that Guy's men will have a rude awakening when they start practice in lesss salubrious places. The assassin, infantile diarrhœa, may have " dropped his cloke and dagger and fled," but it seems that he fled to the Midlands. Of the ten cubicles in my ward at the moment, five are filled with babies with severe diarrhœa, three of them being on continuous " drips." We now call broncho-pneumonia " disseminated pneumonia," and most of them get well, but I have seen two P.M's recently on children with the condition ; and in cities where women habitually go out to work even in peace-time, the prevalence of bottle-feeding produces a certain number of cases of the cow-milk atrophy type. Were there no nervous mothers with wind-sucking babies during the " Blitz " ?

These remarks only emphasise how great a work has been done at Guy's since Dr. Cameron put his capable hands to the plough. It is indeed a pleasure to know that his work is now appreciated ; it was not always so. I am confident that I am expressing the feelings of all his past H.P's and clinical assistants when I say that to have worked with Dr. Cameron is a life-long inspiration, and I trust that with more time at his disposal he will give us further and fuller records of his wisdom.

I am, etc.,

Crow Lees, 7, Springfield Road, Leicester, J. VERNON BRAITHWAITE.

Pembury at War

BY E. W. GRASBY, ESQ., Medical Superintendent.

THE first alert, grim reminder of the beginning of the War, was followed within twenty-four hours at the County Hospital, Pembury, by an immediate invasion of some 140 Guy's medical students completely unheralded and unannounced, but each bearing a strange device announcing that in the event of hostilities he was to report to the Medical Superintendent for duties, which each did personally and most punctiliously.

A more gentle invasion was that of a contingent of Guy's nurses, for whom there was no accommodation whatever, although we did our best.

The period of the 'phoney War was thus occupied in housing and occupying our guests and preparing for future eventualities. Six large marquees were erected in sylvan settings and nurses literally "camped out." In response to urgent appeals for beds a deluge of iron-work appeared adjacent to these tents and, on analysis, proved to be Guy's and L.C.C. beds—voluntary and municipal, like trusted friends, "grappled together with hoops of steel."

In due course Government beds of the truly collapsible variety and a double supply of mattresses were supplied, and much later the accommodation in the hospital was increased by the provision of staff and patients' huts.

All this was introductory to our real test in the summer of 1940, when the evacuation from Dunkirk brought us casualties from overseas. We remember the urgent appeal of Professor Johnston to "open up the huts," at a time when the huts were hardly more than skeletons and equipment was almost non-existent!

Of the week during which the epic of Dunkirk was being fought, the tragedies do not bear repetition, but certain things will always be remembered. The aged Belgian, swept with the rush to England and, midst the clamour, incongruously complained in piteous tones of a lost coat, the severely wounded French soldier, whose only request was "*Ou est mon baton?*" which was discovered to be a large wooden club with which he was determined to decimate the ranks of any Germans he met and the sigh of relief he gave when his *baton* was restored to him. Then there were the collections of lethal weapons, knives and cartridges, which were secreted in the wards until rounded up and sent to "Dados" and "Maroc," the very wet, very sad and nearly drowned Moroccan troop, who somehow was landed with a British contingent.

The work of the surgeons will never be forgotten, the skill of the Senior Staff, particularly Philip Turner and E. C. Hughes, in deftly removing shrapnel—there was almost a continuous rattle in the theatre buckets!—the keenness and enthusiasm of the younger men, "J. J.", and "Kilp" and Darling, and the indefatigability of the Theatre Nursing Staff, who had to be sent off duty rather than stop in their work. These things will be remembered and the courage and endurance of patients and the superhuman efforts of the Staff.

In June and July, 1940, the peace of the hospital was further shattered by the sudden arrival of coastal evacuees, who were temporarily housed in our new huts pending their removal to the fastnesses of Wales. These poor and mostly aged people were literally torn from their homes in the vulnerable invasion areas and arrived in coaches at all hours of the day and night and in any number up to three hundred at a time. They were rather piteous with their hastily gathered belongings, and their disposal presented innumerable problems in transport and in accommodation, nor did the hospital staff have a light task in handling so many stretcher cases, ending their duties late at night and then beginning to load ambulances again early the next morning. Baitup, head porter, personally handled on one occasion two hundred stretchers in one day.

Of the "Battle of Britain" the hospital had a grand-stand view. Not only did we see daily the hundreds of German bombers streamkng to London, but as we were in the centre of the fighter area, planes literally showered down around us. We are proud to feel that it was our privilege to admit some of "The Few," who so abruptly parted from their planes.

There was X——, whose parachute riddled with holes brought him safely, but all too quickly to earth. There was Y—— from the famous 303 Squadron, whose English was naively profane and who complained, "Six days we fight—only five German planes—*pah*!" There was Z——, who just saved the lives of his crew and of the local villagers by remaining in his plane until the last possible minute and then was chased by his discarded crazy plane, whose revolving propeller neatly amputated the fingers from his right hand as it passed him. There was the Canadian who hit his back on the wireless mast of his diving plane and really was bruised! And the Sergeant-Pilot from the Midland Squadron, in combat for the first time, blasphemous in good North Country dialect for being shot down and not even seeing who did it.

Then there was the Fleet-Air Arm crew in their borrowed plumes looking rather like fair-weather yachtsmen. They were being transferred to the Kent and Sussex Hospital, but stopped on their way to watch a dogfight and arrived to find that a bomb had hit that hospital just ten minutes before—and, roughly, where their ambulance would have been! Such amazing fellows, furious at being shot down and so

grieved at losing good English planes. They never seemed to notice that they had been wounded.

Of the Luftwaffe we thought nothing, but it is understood that the zip fasteners came in useful!

The then Minister of Health, Mr. Malcolm MacDonald, honoured us with a visit during the height of the Battle. As a senior member of the Government continually urging the public *not* to stand out of doors and watch the dogfights, we remember he proved a singularly poor example. During his rapid progress from vantage point to vantage point, we recollect his most urgent plea was for our binoculars to see the battles even more clearly.

It may be here observed that a popular diversion during quieter moments was digging out machine-gun bullets from the asphalt paths.

The winter which began the "Blitz" on London brought warnings night after night, bombs and bombers, and casualties local and from London when the sad convoys from Guy's began. Of those London casualties transferred to Pembury, we remember their grim heroism and their anxious look when bombers still passed overhead every night, perhaps to bomb again their wrecked homes or maim those of their friends remaining in London.

Staff were busy those days, nights were disturbed and sleepless, and while the War news progressively deteriorated their grim work went on relentlessly.

For the next two years casualties, civilian and military, occupied the hopsital in addition to our normal civilian patients and with the progressive improvement in our fortunes overseas our hearts were lightened, but in June, 1944, the flying-bombs curtailed our enjoyment of the good news of "D" Day.

Pembury was on the direct route between the major launching sites in Belgium and London and hundreds passed over the hospital, but although the country around is littered with wreckage of flying-bombs we watched brought down, the hospital miraculously escaped damage. It was a great but dubious pleasure to be able to demonstrate these flying-bombs to the visiting staff from London, and we particularly remember A. D. Marston and the late Harold Chapple watching one of the things being shot down from right over their heads.

We also saw the first flying-bomb to be tipped over by a Spitfire—it fell in Tonbridge and made quite a mess—and we even saw one of the wretched things pass over the hospital, be shot at by fighters and promptly turn round and come back over our heads again to fall, fortunately, away from the hospital.

Just to make things more difficult we found ourselves later in the A.A. gun belt, and the noise of fighters, guns and flying-bombs utterly disturbed our peace. The fact that the A.A. guns were firing with low trajectory, so that shells from distant batteries exploded uncomfortably near our roofs also added to our discomfiture.

The casualties from London swelled the number of patients in the hospital and we remember the multiple "glass" wounds tragically marring young faces.

Later, one of the first rockets to reach this country landed not so far away, and although we heard distant explosions the majority travelled to London again, whence we received yet more casualties from that unhappy City.

We did expect to receive battle casualties from the Continent, but transport and disposal of the wounded was so efficient that, we understand, the more westerly ports were able to handle them and send them quickly to hospitals in the North. At the same time "Bomb Alley" and South-Eastern England generally was still far from healthy. We did, however, "stand and wait"—a form of service which we believe is fully acceptable in higher places, although somewhat less acceptable we found, as an enforced habit in Staff anxious and impatient for genuine hectic duty.

And now the Guy's nurses and medical students are returning to London, many of our E.M.S. wards are closed and we are returning to a modified pre-war normality. But we shall never be quite the same again. We shall always have memories of these war-time experiences we shared in Sector 10 and, we hope, continue our happy association with Guy's, ties which we feel will be strengthened by those of the Guy's Medical Staff, who happily will be staying with us.

House Officers—Sector 10

NOVEMBER 1ST, 1945, TO JANUARY 31ST, 1946.

Remaining	*New Appointment*	*Transferred from*	*Transferred to*	*Retiring*
GUY'S. Batty Shaw, A.(B.2) Macrae-Gibson, N. K. (B.2). Thomas, J. M. (B.2). Thorne, M. G. Kinder, C. H.	Allenby, K. D. O'Keeffe, D. Montgomery, P. R. Neve, C. R.	Reinhold, J. D. L. (B.2). from Orpington. Woodside, R.M. (B.2), from Wildernesse.	May, P. R. A. (B.2), to Farnborough.	Pentney, B. H. Huntley, A. M.
WILDERNESSE. Fox, W. (B.2).	Roberts, C. G.		Woodside, R. M., to Guy's.	
JOYCE GREEN. O'Connor, D. Morse, A. V. (B.2). Vidot, C. C. (B.2).	Porges, K. I.			
PRESTON HALL.	Lee, W. R.	Rudman, D. J. (B.2), from Queen Mary's, Sidcup.	Walton, R. G., to Pembury.	
ORPINGTON. Van Diggelen, H. (B.2). Green, R. A. Barclay, R. F. (B.2).	Shaw, J. F.	Nicholson, D.P. (B.2) from Farnborough.	Reinhold, J. D. L. (B.2) to Guy's.	Cashmore, A. A.
FARNBOROUGH.	Young, F. R. M. Campbell, K. A. A.	May, P. R. A. (B.2), from Guy's.	Nicholson, D. P. (B.2), to Orpington.	Haas, G. J. The, I. T.
PEMBURY. Watford, N. C. J. (B.2). Wallace, J. D.	Griffiths, G. E. King, M. B.	Walton, R. G. (B.2), from Preston Hall.		Macdonald, I. Pearson, P. F.
SOUTHERN. Bensted, J. P. M. (B.2). Breeze, D. G.	Chin, K. H. Huntley, J. D. Jones, T. J. Forrester, G.			Ebsworth, J. S. Davies, D.
QUEEN MARY'S.	Fifield, J.		Rudman, D. J., to Preston Hall.	

Guy's Hospital Clubs' Union

SAILING CLUB

THE Guy's Hospital Sailing Club this year reaches its twenty-first birthday. Admittedly this is no great age compared with such clubs as the Rugby Football Club, but during its minority the Sailing Club has well upheld the honour and tradition of Guy's. When the United Hospitals' Sailing Club abandoned its sailing at Burnham-on-Crouch in 1939, the Hospital held three of the seven challenge cups, and in the first season of war-time inter-hospital races in 1944, was placed second of the eleven constituent members, losing first place to St. Thomas's by one point.

The achievements of the Club during the War have been due to the efforts of a small band of keen sailing men, so freshmen with experience of yacht racing will receive a hearty welcome; the inexperienced, however, are not excluded, as it is usually possible to coach them by means of lectures or actual practical experience.

Six U.H. 1 design fourteen-foot lug-sail dinghies are available for sailing at the war-time headquarters of the Club at Hammersmith, with certain rules and regulations governing their use.

There is a limited membership, no more members being admitted until the next general meeting in January, when vacancies for from thirty-five to forty will exist.

At the end of this season (October 24th) a report will be issued, giving details of the races in which Guy's members have taken part, and also the result of the inter-hospital matches.

Newcomers who are interested should watch the notice-board in the Colonnade or contact D. J. Reid (Hon. Secretary).

D. J. REID.
(Hon. Sec., United Hosps. S.C.).

THE ATHLETIC CLUB

DURING the War years a few sporadic, but unsuccessful, attempts were made to revive the Athletic Club, which, before the War, had a high reputation. Between 1940 and 1944 such athletes as the Hospital possessed—if they were capable enough—represented the London University Tyrian Club. This was unsatisfactory because it meant that a number of less skilled athletes were, of necessity, ignored. An attempt is now being made to run the Club on former lines, so that all those who wish to take an active part in athletics may do so.

There are many difficulties. Some potential athletes play rugger in the winter and spring or cricket in the summer; others are members of the Boat Club. These major sports very naturally take pride of place. The practical difficulties are shortage of equipment and, owing to lack of ground staff at H.O.P., the preparation and maintenance of a track. For the present, therefore, we must rely on "away" fixtures.

As a start, matches are being arranged with accessible Public Schools and, it is hoped, with other hospitals and the universities. To put a comprehensive programme of this kind into operation we must be certain of the support of all available athletes. In the matches against Bedford and Tonbridge Schools, which we won earlier this year, some of our representatives took part in four or five events during the afternoon. This state of affairs must be avoided in the future.

Those interested should add their names to the list in the Colonnade. A general meeting will be held as soon as practicable.

RODNEY LONG, Captain.

NON AFFILIATED

MUSIC CLUB

A CLUB has been formed to promote musical activity in the Hospital. A constitution is being prepared, and it is proposed that the club should seek affiliation to the Clubs' Union. Mr. E. W. Baxter has been elected Hon. President.

R. G. Larson is arranging chamber music practices, and it is hoped that an orchestra may soon be started.

Gramophone concerts have been held weekly for the past year, and these will continue to take place on Wednesdays at 1 p.m. in the New Theatre. It is intended that two or three full-scale concerts shall take place in the late afternoons on dates to be announced shortly. Further weekly midday concerts will be arranged, programmes being devoted alternately to instrumental, operatic and light orchestral music. Further details may be obtained from L. C. Kreeger and R. G. Fricker.

Madrigal singing is being arranged by R. H. H. Wyman. P. Maxwell-Stephens and P. C. S. Campion have been holding meetings to sing students' songs on Tuesdays and Thursdays. Details of these are available from the ospital Hnotice-boards.

Anyone interested in any of the present activities of the Music Club are asked to contact any of the above, either personally or by means of a note left in the Colonnade letter-rack.

A. J. SALMON (Hon. Sec.).

Sport

Rugby

GUY'S *v.*
OLD PAULINES—CRANLEIGHANS.
(*Played at Thames Ditton on October 20th,*)

Result: 2 goals, 4 tries and 2 penalty goals (28 points) to 1 try and 1 penalty goal (6 points).

Guy's defeated the Old Paulines-Cranleighians by 28 points to 6 points.

D. Le Clus remained at full back and B. Ehrsteen and T. K. Walker came into the back row of the scrum owing to the injuries of P. Carton-Kelly and M. Hatton.

Guy's were quick to show their superiority n the three-quarter line and within six minutes of the kick-off had scored twice through Macrae-Gibson after a beautiful run, and De Villiers after a movement by Van de Westhuizen and F. Le Clus.

After this brilliant start the game settled into a battle for possession, our opponents fighting hard to keep the ball from our three-quarters. From time to time we would get it back and then it would look dangerous for the Old Paulines. Vann, at scrum-half, had some difficulty from forwards breaking through line-outs on to him and was hampered in getting the ball away.

All the backs played well, there being several very thrilling movements. Perhaps the best was when Dwyer, after receiving the ball from a three-quarter movement, gave a perfect inside pass back to Van de Westhuizen, who went over for a try.

Of the forwards there is more to say. We were as tall as they, but they got the ball from line-outs. It was plain to see that they were jumping higher. In the loose scrums we were not getting our fair share of the ball either; here, of course, the first foot over the ball should heel it and not remain stationary.

In the pack Hilliam, MacCallum and Dean did the lion's share, and Ehrsteen and De Villiers spoilt a great number of the Old Paulines' movements. The tackling all round was good, and the Old Paulines did well to break through once to score.

A feature of the game was the great number of penalty kicks awarded, Jones kicking two long ones for us, Macrae-Gibson, on the wing, scored three well-earned tries; and De Villiers, Van de Westhuizen and F. Nellus got one each. Jones converted two of these.

Association

GUY'S *v.* NORSEMEN.
(*Played at H.O.P. on Saturday, October 13th.*)
Result: Won (4–0).

The Guy's team underwent some minor rearrangements for this match. As one might gather from the score, this experiment was completely successful. Within one minute of the kick-off D. J. Foster had scored for Guy's. After this initial success Guy's attacked furiously and completely dominated the game. The Norsemen, however, defended, their goal very well and it was not until a few minutes before half-time that D. J. Foster scored again for Guy's.

The second half was very similar to the first, the ball remaining in the Norsemen's half of the field almost all the time. Two further goals were added in this half by R. K. Foster and A. E. Trist. Although a 4–0 victory was good, it was the impression of many observers that the score should have been very much greater.

Special mention should be made of A. E. Trist, who played excellently for Guy's.

Team.—J. Deutsh; E. M. Newton, R. A. C. Dove; M. J. L. Sykes (captain), H. R. C. Riches, C. S. Matthews; I. A. H. Munro, D. J. Foster, R. K. Foster, A. E. Trist. R. Owen.

Hospital Information, etc.

Notices

On Wednesday, December 19th, 1945, the 1st XV are playing Paris University at Honor Oak Park. An appeal is made for offers of accommodation for the members of the French team during their stay in this country. They will be provided with food permits and will stay here for one or two nights.

Offers will be received by Mr. P. Winston, The Wills Library, Guy's Hospital.

CENTENARY BALL.

The Boat Club Centenary Ball will be held on Friday, November 30th, 1945, from 8 p.m. to 1 a.m., in the Vintners' Hall, and double tickets will be 30sl This will include all solid and liquid refreshments. Applications for tickets should be made to T. H. S. Burns at Guy's Hospital, and cheques should be made pable to Guy's Hospital Boad Club Ball.

Pass List

GENERAL SECOND EXAMINATION FOR MEDICAL DEGREES.
(For Internal Students.)
September, 1945.

E. Beswick	T. E. Jeffreys
G. Canty	A. E. McLauchlan
J. T. Cecil	A. H. Mendoza
P. R. Chalk	N. H. Porter

UNIVERSITY OF OXFORD.
B.M., B.Ch.
October, 1945.

Forensic Medicine and Public Health.

H. L. Backhouse	G. A. K. Missen
T. H. S. Burns	G. M. Woodman

Special and Clinical Pathology.

H. L. Backhouse	G. A. K. Missen
E. L. Magee	G. M. Woodman

General Pathology and Bacteriology.

J. H. B. Yule

Elementary Biology.

C. B. Bowes	P. A. Van der Merwe
A. C. de B. Eksteen	F. J. H. Van der Westhuizen
W. R. Thomas	R. V. Warren

L.D.S.
FIRST AND SECOND PROFESSIONAL EXAMINATION.
September, 1954.

Dental Metallurgy.

E. J. Annen	R. Karat
D. G. Bunker	D. J. Murch
W. Finkel	P. H. Tucker
P. Griffiths	P. J. Wright
R. A. Hill	

Dental Mechanics.

M. W. Harber	D. Rabinovitz
D. W. Leatherbarrow	A. P. Rowland
J. K. Keen	D. F. Waller
J. W. McLean	K. D. Watts
I. A. Nelson	C. R. Wilkinson

Anatomy and Physiology.

A. A. Bailey	M. P. O'Reilly
E. B. Busfield	D. Rabinovitz
E. J. Deutsch	R. E. Simmons
B. Engelsman	D. F. Waller
T. R. Foster	J. R. Waller
A. W. Hilliam	C. R. Wilkinson
J. W. McLean	

Special Anatomy and Physiology.

I. B. Walters	S. F. A. Westgate
I. A. Nelson	C. W. H. Williams
P. S. Holmes	

CONJOINT BOARD.
FIRST EXAMINATION.
June, 1945.
Anatomy.

R. J. Aspinall	D. B. Davies
K. A. Baker	A. R. Davis
H. E. Braun	D. H. Griffiths
G. Canty	D. F. Potter
P. R. Chalk	E. J. Stafford
D. G. Chalmers	F. R. H. Wrigley

Physiology.

H. E. Braun	D. H. Griffiths
J. T. Cecil	B. Plant
D. G. Chalmers	F. R. H. Wrigley

Pharmacology.

R. W. Day	J. B. Moore
J. J. Fingard	S. G. A. Shute
T. R. L. Finnegan	M. D. Warren

CONJOINT BOARD.
FIRST EXAMINATION.
September, 1945.
Anatomy.

J. B. F. Boyle	P. B. Poole
A. K. Doust	I. A. W. Scott
S. A. Jolliffe	

Physiology.

K. A. Baker	D. F. Potter
J. B. F. Boyle	R. D. Walsh
A. R. Davis	C. S. Ward
A. K. Doust	

Pharmacology.

J. B. Eades	J. Southgate
T. E. Oppé	P. Wilson
W. E. Macbean	

Prize Awards

October, 1945.

The following awards have been made :—
Junior Proficiency Prize—R. A. J. Mayhew.
David Frank Sturdee Prize—R. A. J. Mayhew.
Prize in General Subjects—S. J. Bell.
Prize in Special Anatomy and Physiology—J. S. Rose.

The Blues' Committee

At a recent meeting of the Blues Committee the following awards were made :—

Cricket.—Full Blues : E. W. Graham, A. E. Trist. Half Blues : I. A. H. Munro, W. B. Webb, J. D. Williams.

Lawn Tennis.—Full Blue : P. J. Dwyer. Half Blue : A. J. M. Starte.

Boat Club.—Half Blue : J. Inskip, F. De Hamel, A. F. Crick.

Fencing Club.—Half Blue : C. R. Neve.

Swimming.—Full Blue : R. Illiffe, J. Keeling, R. A. Dean. Half Blue : B. N. Gray, D. Walker.

Sailing.—Full Blue : D. J. Reid, E. B. Elphicke.

L. D. Carton-Kelly was elected secretary for the ensuing year.

A. Batty Shaw,
Hon. Sec., Blues Committee.

Change of Address

C. G. Baker, O.B.E., M.D., Selly Oak Hospital, Birmingham. (Tel. : Selly Oak 1361.)
S. E. Beaton, Lieut., A.D. Corps, No. 9 Field Dental Centre, M.E.F.
R. Cope, M.B., B.S., 21, Acacia Road, N.W.8. (Tel. : Primrose 0021.)
G. W. Downes, Capt., R.A.M.C., M Branch, B.M.A., Cyrenaica, M.E.F.
G. B. Ebbage, D.O.M.S., 1, Duke Street, Manchester Square, W.1. (Tel. : Welbeck 5217.)
M. A. Filose, Capt., R.A.M.C., 13/19, The King's Royal Hussars, M.E.F.
R. J. G. Grewcock, 27, Wimpole Street, W.1 ; and 44, Wickham Way, Beckenham, Kent. (Tel. : Langham 1833 and Beckenham 1047)
D. J. Humphris, Capt., A.D. Corps, No. 6 B.F.A., S.E.A.C.
T. B. Layton, D.S.O., M.S., Nuffield House, Guy's Hospital, S.E.1.
W. B. D. Maile, S/Ldr., R.A.F., Hdqrs. No. 2 Group (Ind.), R.A.F., India Command.
W. S. McConnell, M.B., B.S., 47, Wimpole Street, W.1.
A. G. Ord, F.R.C.S., Freestone House, Freestone Road, Southsea.
R. A. Ratcliff, M.D., 3, Westcote Road, Reading.

Births

COX.—On August 17th, 1945, at Maidstone Kent, to Jean (née Tomlin), wife of John Cox—a son (Christopher John).

ELLIOTT.—On October 27th, 1945, to Bets (née Lowe), wife of John Elliott, M.B., of Hambleden, Henley-on-Thames—a daughter Christine Elizabeth.

Marriages

GREEN—GARLAND.—On September 6th, 1945, at Leigh-on-Sea, R. C. Green, Capt., A.D. Corps, to Margaret Garland.

HILL—GRICKS.—During October, 1945, Adrian G. W. Hill, of Vine Cottage, Lyndhurst, to Barbara Mary Gricks, Jr. Cmdr., A.T.S., of Mile End Close, Norwich.

MIDDLETON—PILLAR.—On August 23rd, 1945, at St. Jude's Church, Plymouth, Donald Middleton, Capt., A.D. Corps, to Barbara Pillar, elder daughter of Mr. and Mrs. H. C. Pillar, of Plymouth.

Deaths

CLARK.—On October 16th, 1945, Robert Clark, Head Mechanic for thirty-seven years, Guy's Dental School.

DENTON.—On October 28th, 1945, at Strathallan Nursing Home, Bournemouth, George Robert Denton, M.B., C.M., aged seventy-five years.

DURHAM.—On October 25th, 1945, at 14, Sedley Taylor Road, Cambridge, Herbert Edward Durham, Sc.D., F.R.C.S., aged seventy-nine.

GILLESPIE.—On October 30th, 1945, at Guy's Hospital, Robert Dick Gillespie, M.D., F.R.C.P., D.P.M. (late Air Comdre., R.A.F.V.R.), aged forty-eight years.

MARS.—On October 26th, 1945, in Pretoria, Joan, wife of Paul E. Mars, L.M.S.S.A.

STRICK.—On August 9th, 1945, Helen Harriet Strick (Guy's, 1885), Lady Superintendent, Guy's Trained Nurses Institute, 1913.

Eds. {M.G.T. J.M.H.

CLOSELY ASSOCIATED WITH THE MEDICAL PROFESSION FOR OVER 100 YEARS

Why not Consult the

CLERICAL, MEDICAL AND GENERAL LIFE ASSURANCE SOCIETY

Old and intending clients will be pleased to know that many of our Branches (closed during the war) have now been re-opened and enquiries addressed as below will receive prompt attention.

BRANCH OFFICES :—

BIRMINGHAM—84, Colmore Row, 3.
BRIGHTON—116/117, North Street, 1.
BRISTOL—16 & 18, Clare Street, 1.
CARDIFF—26, Windsor Place.
CROYDON—110A, George Street.
EDINBURGH—9, South Charlotte Street, 2.
GLASGOW—179, West George Street, C.2.
IPSWICH—34, Princes Street.
LEEDS—Martins Bank Chambers, Park Row.
LIVERPOOL—"K" Exchange Buildings, Exchange Street East, 2.
MANCHESTER—Ship Canal House, King Street, 2.
NEWCASTLE-ON-TYNE—Standard Chambers, Neville Street, 1.
NOTTINGHAM—24, Low Pavement.
SOUTHAMPTON—Lloyds Bank Chambers, 18, High Street.

LONDON :

Chief Office : **15 St. James's Square, S.W. 1.** *Tel. Whitehall* 1135
City Office : **36/8 Cornhill, E.C. 4.** *Tel. Mansion House* 6326.
Law Courts Office : **58 Carey Street, W.C. 2.** *Tel. Holborn* 1840

'AVLON'
brand of
PHENOBARBITONE B.P.
(5-phenyl-5-ethylbarbituric acid)

Phenobarbitone B.P. possesses anti-convulsant properties which make it especially valuable in the treatment of epilepsy.
In insomnia and anxiety states it may be used as a general hypnotic to produce sleep.
The distressing spasmodic attacks which occur in whooping cough, tetanus and eclampsia have been reported to be lessened by phenobarbitone.
Further information and technical literature will be forwarded on request.

PACKINGS

Tablets: ¼ *grain,* ½ *grain,* 1 *grain and* 1½ *grain.*
Bottles of 25, 100 *and* 500.
Obtainable from your usual suppliers.

A product of
IMPERIAL CHEMICAL [PHARMACEUTICALS] LTD.
89, OXFORD STREET, MANCHESTER, 1

Ph.107f

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1496 *24th November, 1945* *Ninepence*

PASSIM

AT the Service of Remembrance, held round the Memorial Gateway on Sunday, November 11th, 1945, homage was paid to the dead of the two wars. Readers will wish the names of those who fell between 1939 and 1946 to be recorded; accordingly we publish in the following pages a Guy's own Roll of Honour. We trust that omissions have been few.

THE doctrine of *laissez faire*, extinct as a political policy, appears to obtain continued and constant support in certain quarters of the Hospital. This anyway is a possible reason for the almost uniform absence of attention paid by those who wield constructive power, to opinions, requests and suggestions appearing in the pages of this journal. These suggestions, though not frivolous and for the most part not impracticable—if indeed they are read by those to whom they are virtually addressed—are apparently either rejected out of hand or put into only the most gradual and clandestine effect. When, for example, is a clinical laboratory for the use of students clerking in wards to be equipped? Is the installation of a microscope in the post-mortem room so completely impracticable that it deserves neither to function nor to be commented upon? These are but two of many topics recently discussed in this journal and, as in other cases, there is no indication that the pages of the *Gazette*, which could be used as a doorway to the achievement of constructive change, has been permitted to fulfill that role.

Dr. M. J. F. McArdle, Mr. W. G. Gill and Mr. J. H. Mayer have returned to Guy's from the Forces; readers will wish to join us in welcoming them back. Their reappearance will doubtless soon make its influence felt on the teaching at Guy's.

MISS Dorothy M. Smith, O.B.E., Matron of the Middlesex Hospital, has accepted the invitation of the Governors of Guy's Hospital to become the Matron to succeed Miss E. E. P. MacManus, O.B.E., who is retiring from the service of the Hospital in the early part of 1946.

WE would like to congratulate Miss Bell, Lady Superintendent of The Wildernesse, on being appointed Matron of the Leicester Royal Infirmary, and wish her happiness and success in her new work. Miss Bell is the third Guy's nurse to fill this post.

ATTENTION is drawn to advertisements for four vacancies on the Visiting Staff of the Hospital, which will appear in *The Lancet* and the *British Medical Journal* of December 1st, 1945.

Roll of Honour

Surg. Rear-Admiral G. L. Buckeridge, C.B., O.B.E., R.N. Died in London.
Lieut. A. S. Carruthers, R.A.M.C., Died in India.
Captain A. D. Chaundy, A. D. Corps. Killed in action in Western Europe.
Surg.-Captain A. E. P. Cheeseman, R.N. Reportrd killed.
Corporal G. H. C. Clarke, R.A.F. Killed.
Surg.-Cmdr. A. W. Cocking, R.N. Died at Barrow Gurney Naval Hospital.
Temp. Surg.-Lieut. J. S. Crone R.N.V.R. Lost at sea, serving on H.M. Submarine *Starlet.*
Surg.-Lieut. M. C. Cross, R.N.V.R. Missing; presumed killed in H.M. Minesweeper *Clacton.*
Captain H. T. Crowdace, S.A.M.C. Killed in action November, 1941, at Battle of Sidi Rezergh, Egypt.
Surg.-Lieut. P. S. Cuthbertson, R.N.V.R Reported missing in action, and presumed killed.
Surg.-Lieut. G. L. Cutts, R.N.V.R. Died following an operation.
Captain J. T. Doyle, R.A.M.C. Killed in action in N.W. Europe.
Surg.-Lieut. J. W. Drury (D.), R.N.V.R. Died at Colombo.
Captain A. E. Farara, A.D. Corps. Died.
Surg. Lieut.-Cmdr. C. H. Egan, R.N. Reported missing from H.M.S. *Glorious*; presumably dead.
Surg.-Cmdr. W. C. G. Ford (D.), R.N. Died as the result of an accident.
Major R. L. Frost, I.M.S. Died.
Lieutenant J. J. Gaterell, A.D. Corps. Died.
Major R. G. Gayer-Anderson, R.A.M.C. (ret.). Died.
Lieut.-Col. C. G. G. Gibson, R.A.M.C. Died on active service.
Lieut.-Col. E. G. Goodall, C.B.E., R.A.M.C. Died.
Lieut.-Col. L. A. J. Graham, R.A.M.C. Died on active service.
Major A. C. Greene, I.M.S. Died in India.
Surg.-Lieut. R. L. Greenfield, R.N. Reported killed on active service.
Captain K. H. Greenwood, R.A.M.C. Died at Cairo Base Hospital.
Dr. S. D. Hankey. Died of typhus at Tali in Western Yunnan.
Captain Leslie P. Harte, A.D. Corps. Died on active service through enemy action at sea in evacuation from Greece.
Surg.-Lieut. F. M. Hayes, R.N.V.R. Reported missing; believed killed.
Captain F. R. Hayward, R.A.M.C. Died.
Lieut. A. E. Hill, R.A.M.C. Died.
Captain E. J. F. Hinde, R.A.M.C. Reported missing at sea; presumed dead.
Captain (temp. Major) H. M. R. Knight, R.A.M.C. Reported missing; later reported prisoner-of-war; and, lastly, recorded killed in action.
Lieut. G. R. Lamont, A.D. Corps. Died suddenly.
Flying-Officer A. S. Lee, R.A.F.V.R. Reported killed in flying accident.
Major G. A. M. Lintott, R.A.M.C. Died whilst serving in Egypt.
Captain A. E. Locke, R.A.M.C. Died.
Colonel David Lurie, S.A.M.F. Killed in motor accident in Egypt.
Surg.-Lieut. A. C. Macrae-Gibson, R.N.V.R. Died as the result of an accident abroad.
Captain D. F. Malt, A.D. Corps. Died.
Surg.-Lieut.-Cmdr. L. Merrill, R.N. Reported missing on active service; later reported killed.
Captain T. E. Mitchell, R.A.M.C. Died on active service.
Captain M. R. Mullins, S.A.M.C. Died in Italy.
Captain J. B. C. Murdoch, R.A.M.C. Died on active service.
Captain E. J. A. Needham, R.A.M.C. Reported missing, and later reported officially presumed lost at sea.
Surg.-Cmdr. D. A. Newberry, R.N. Reported missing; later reported believed killed serving on H.M.S. *Repulse.*

Surg.-Lieut.-Cmdr. JOHN W. OLIVER, R.N. Lost at sea whilst serving in H.M.S. *Bonaventure.*
Wing-Cmdr. R. M. OUTFIN, R.A.F. Killed on active service.
Surg. Lieut.-Cmdr. G. PATTERSON, R.N.V.R. Died.
Surg.-Lieut JOHN E. G. PEACOCK (D.), R.N.V.R. Drowned at sea in action whilst serving on H.M.S. *Hood.*
Lieut.-Col. C. M. PLUMPTRE, I.M.S. Died.
Flt.-Lieut. W. S. PITT-PAYNE, R.A.F.V.R. Died on active service.
Lieut. A. C. POWELL, R.N.V.R. Killed when aircraft crashed into sea.
Lieut.-Col. W. L. E. REYNOLDS, R.A.M.C. Drowned at sea by enemy action.
Surg.-Lieut. J. W. RHYS, R.N. Presumed to have been lost at sea when H.M.S. *Glowworm* was sunk.
Lieut.-Col. JOHN J. F. ROONEY, I.M.S. Died.
Surg.-Lieut. E. R. ROSEVEARE, R.N.V.R. Died in a sanatorium.
Lieut.-Col. A. F. SALSBURY, A.D. Corps. Died.
Captain R. M. SHARPE, R.A.M.C. Reported missing at sea.
Lieut.-Col. A. SIMPSON-SMITH, R.A.M.C. Reported prisoner-of-war in Italy; later unofficially reported killed.
Surg.-Lieut.-Cmdr. JAMES G. SLIMON, R.N. Died as result of an accident.
R. SOUTH, L.M.S.S.A. Merchant Navy. Lost at sea when ship torpedoed.
Surg.-Lieut. E. A. SPOUSE, M.B.E., D.S.C. Lost at sea; presumed killed.
Surg.-Lieut. P. G. STAINTON, R.N. Killed in motor accident at Cape Town.
Lieut. H. P. STEBBINGS, R.A. Killed in action in Middle East.
Surg. Rear-Admiral G. F. SYMS, R.N. (ret.). Died.
Major T. F. TODD, R.A.M.C. Died on active service.
Lieut. H. D. VENNING, R.A.M.C. Killed in action in Middle East.
Captain E. S. WALMSLEY, General List. Killed in action near Paris.
Captain V. C. WARR, A.D. Corps. Died of wounds received in action.
Surg.-Lieut. F. H. J. WESTON, R.N.V.R. Lost at sea whilst serving on H.M.S. *Rawalpindi.*
Lieut. W. F. J. WESTON, R.A.M.C. Missing in Malaya; later reported died in Singapore
Flt.-Lieut. S. WETHERELL, R.A.F.V.R. Killed by enemy action in Burma.
L/Cpl. JOHN WHATLEY (Commando). Killed in action.
Sqdr.-Ldr. J. N. WILLIAMS, R.A.F.V.R. Died.
Captain G. E. YARDLEY, R.A.M.C. Died of wounds in Italy.
Captain W. E. YOUNG, R.A.M.C. Killed in action in Libya.

NURSING STAFF.

Miss WINIFRED RUSSELL (1914–1917). Killed by enemy action.
Miss BARBARA LEECH (1938–1942). Killed by enemy action.
Miss EILEEN M. IEVERS (1918–1921). Killed by enemy action.

ADMINISTRATIVE STAFF (Hospital and School)

Mr. GEORGE GREEVES, Senior Technician, Pathology Dept. Killed by enemy action.
PATRICK L. PHILLIPS. Clerk in Counting House. Died on active service.
GEORGE WALL, Porter in the Superintendent's Stores. Killed by enemy action.
Mrs. MAUD STEELE, Portress in the Superintendent's Stores. Killed by enemy action.
ARTHUR WARREN, Gardener on the Works Department Staff. Killed by enemy action.

DOMESTIC STAFF.

Miss ROSE COOPER, Head Dressmaker. Killed by enemy action.
Mrs. KITTY SHELFORD, Daily Cleaner. Killed by enemy action.

"Dare Quam Accipere"

An Appreciation

DR. R. D. GILLESPIE, M.D., F.R.C.P., D.P.M.

THE death of R. D. Gillespie comes as a great shock to his many friends and patients; universally loved and respected, his going creates a blank it will indeed be hard to fill. He died young, but he died in the fullness of his power—never having had to bow the knee to expediency or dim his clear truthfulness. That, I think, is a gain before which death is a poor intruder.

Gillespie's name will always be linked most happily with that of Guy's Hospital; it was here that he started his Child Guidance Clinic, in a small room at the top of the building. With no red tape, ample mind room, and opportunity for all to develop healthily, throwing off their mental cobwebs or physical disabilities, the children throve amazingly. We tried to keep the numbers down to twelve, all ages, from three to seventeen, and had many enlightening and amusing times. Our bi-yearly parties were a great success; dirty sweets, cake crumbs, biscuits and crackers were smuggled in. "R. D." was reft from amongst his students and, egged on by cries of "Ow be a sport!" played "nuts and may" with gusto, a bunch of children hanging round his waist and spurring him on to greater efforts.

Many pictures arise: the little boy who had one kindey and never enough to eat, and would come in tightening his belt because he had had no breakfast; the fat one in the corner who brought a bag of buns and ate too much; the sisters of tempestuous little boys, who would interfere with them, and who were at last sat to knit on a high slate shelf; Rosy, who had been sent to us because she had not spoken for two years, and who, in a moment of intense longing at one of our parties, shouted "I want that little cow," and ever after was normal and voluble; Jimmie, who got hung out of window by a boon friend, because he wouldn't play proper, and was retrieved as his shrieks grew particularly piercing; Edward, who sang like an angel; and Barbara, who continually stood on her head, and is now one of the prettiest waitresses at the Admiralty, presumably the right way up.

We were all equals; we painted, we drew, we spun tops, and we told each other our dreams—happiness, hope and affection. I vow there is no childish trouble, fault or sorrow that these will not cure. "R. D." proved it.

An eminent man when he came to London, he became more so as the years went by till, at the outbreak of war, he threw up all his extremely lucrative posts and joined the R.A.F. It was when he reached the post of Air Commodore that he developed a serious illness from which he never entirely recovered; he fought gallantly on, and it was only at the hour of death that he ceased to work for others.

It is "R. D."s transparent honesty and goodness that will live in our minds; add to these his humility and brilliance, and we have a rare and refreshing combination.

A fitting memorial will be found for such a man, but his living memorial will be found in the peace and hope he has brought to so vast a multitude of people, and his glory will be in our own continued efforts; in this way, and this alone shall we keep his work and memory alive, and do honour to a very gallant gentleman. G. B.

A SYNOPSIS AND AN APPRECIATION OF HIS WORK AT GUY'S, 1928–45.

THE work of Gillespie at Guy's offers a remarkable example of his genius. In certain respects its development has a quality of inevitability which is misleading. The facilities which exist in the department of Psychological Medicine to-day did not arise by chance. They grew slowly and at times painfully to meet needs which were not always fully appreciated by others at the beginning. Nor were they modelled upon existing institutions in British medicine. Gillespie pioneered in the truest sense. Where he led others have followed, and though the path may now seem clear enough, it is so because he found it.

This quality of inevitability is often characteristic of true creative work. The clever, the unusual, the spectacular may compel attention by standing in contrast to its environment. Greatness has a way of changing the environment like some subtle catalyst so that everything moves into a new pattern of integration. There is, then, not contrast, but general progress in which the previous lower level is blurred and forgotten. When the change has been made it is felt instinctively to be right just as a great work of art is felt to be right. It is apt to be forgotten that neither progress nor great works of art arise by instinct alone. They require a threefold combination of vision, hard work and creative power.

The soil at Guy's was a good one for the growth of Gillespie's ideas and plans. The Hospital had, from its foundation, an interest in, and a care for, the mentally sick and the rapid development of special laboratory techniques in medicine had not overlaid its great humane and liberal tradition. The times, too, were favourable since the experience of the first world war had aroused an interest in the problems of the mind which was beginning to overcome old prejudices and suspicions.

Thus the way was open, but in order to appreciate how far the department of psychological medicine travelled along it under Gillespie, it is necessary to cast one's mind back to the late nineteen twenties. There arises a rather hazy recollection of a corner of the old Out-patients' Department in which adults and children were crowded together indiscriminately, and in which there was little opportunity for privacy of any kind. Adequate psychiatric social service, help in psychological testing or secretarial help were all dreams of the future. Gillespie, however, lived with a vision of this future which annulled present discomforts. He worked unperturbed by all such difficulties and the writer has a vivid mental picture of him about this time. It was winter and very cold and something had gone wrong with the heating system. In addition to the usual bedlam of the crowded session there was a sound of violent hammering very close at hand where workmen were building the new Out-patients' Department. He sat at his desk, his hands blue with cold, his long legs stretched characteristically out in front of him, discoursing philosophically upon psychological types to a half-frozen ward-clerk who was longing for an overcoat and wishing that psychiatry was a less sedentary subject. At last some one plucked up courage to say that it was cold and to ask that an open window beside him might be shut. It was characteristic of the man that he had noticed neither the cold, nor the noise, nor the open window which was augmenting both.

He was then, as always, half dreamer and half man of affairs, a combination of practical good sense and impracticability. In the realm of the mind he was completely self assured, but mechanical contrivances seemed to fill him with horror. His apparent innocence of certain ways of the world could often be misleading, for, like Chesterton's Father Brown, he had a knack of seeing further than most people into the heart of things just when one least expected it.

The year 1930 marked the occurrence of an important step forward. In this year a full-time psychiatric social worker was appointed to the psychological and neurological departments. At the same time a special attendance day for children was instituted and the nucleus of a child guidance clinic was formed. The new clinic was further aided by the services of a trained psychologist to undertake psychological testing and to give special coaching to backward children. Other workers came forward to give voluntary help in various capacities. It is important to note that this was the first child guidance clinic in London to be part of a voluntary general hospital. It ought, therefore, to be recorded that its first session was held on January 13th, 1930.

The child guidance clinic flourished exceedingly and the whole work of the department received a great impetus by its transfer to what then seemed to be the most spacious premises of the new Out-patient building in 1932. In the following year a fellowship in psychological medicine was endowed at the Hospital by the will of Sir Alfred Fripp, for many years surgeon to Guy's. This, the Sir Alfred Fripp Memorial Fellowship in Child Psychology, brought the work of the department into closer relationship with the children's department and provided an opportunity for special treatment and research.

Thenceforward the story was one of rapid development as Gillespie gathered round him a team of workers, medical and lay, representing many different types of ability, but all inspired by his enthusiasm. In 1934 the Asthma Research Council financed

an investigation into the psychological factors in asthma, and in 1935 the Rockefeller Foundation gave financial support to the programme of reasearch work.

In one sense the growth thus fostered proved an embarrassment, demanding as it did further increases in ancillary services, such as psychiatric social work, secretarial help, etc. One of the problems which psychiatry in the general hospital has to overcome is the relatively high cost of its out-patient service. This is small, for example, by comparison with the capital and maintenance cost of a surgical theatre, but the comparison is not always seen in this light. The cost and elaboration of the out-patient services tend to be compared with those of other departments, with unfavourable reflection upon psychiatric extravagance, whereas a true comparison would be between a psychiatric team as a whole and, say, a surgical team as a whole.

It was, therefore, of tremendous importance that in 1935 a donor, or donors, whose identity has always remained strictly anonymous, came forward with a grant of such generosity that the Out-patient Department was placed on a workable financial basis. This York trust, which was subsequently destined to play a still more important role at Guy's, enabled Gillespie to plan more confidently for the future. It represented a remarkable tribute to his personal achievements, the more remarkable perhaps because his fundamental shyness and diffidence had always first to be overcome before he could turn others to his point of view.

A catalogue of physical progress would be incomplete and one-sided without mention of the change which was coming over the whole attitude within the Hospital towards psychological medicine. This was partly due to a change of orientation in the field of medicine as a whole. But it must not be forgotten that Gillespie himself was as much responsible as any one man for this change. Both inside and outside the Hospital his contacts were very wide. His growing reputation as an erudite yet common-sense psychiatrist, and the high regard in which his published works were held as standard works in the field, brought him an enormous private practice. It was obvious to his friends even in those days that he was slowly killing himself with overwork, but he would tolerate no respite.

One of the weaknesses of which he was most conscious in connection with is work at Guy's was the lack of in-patient accommodation for the treatment of neurosis. Four beds had been set aside for his use in the medical wards. This was a better provision than that existing at many other hospitals, but it was not enough. Among those attending out-patients were a number who urgently needed in-patient investigation and treatment, and for some a long wait meant steady deterioration. Accordingly the high peak of Gillespie's hopes and ambitions seemed to be on the way to fulfiment, when the York Trust offered the funds for the creation of a special psychiatric unit within the precincts of the Hospital. The building was begun before the war and completed during the early period of it. Once again Gillespie's work had helped to show the way, for whereas other hospitals in London were beginning to discuss the need for such a building, Guy's had actually got it.

Of the war years it is not the place of this synopsis to speak. The department of psychological medicine, like other departments, carried on as best it could with a depleted staff. Gillespie served in the R.A.F. with the same zeal and enthusiasm with which he had served Guy's. The York Clinic was used for other purposes. The later stages of the war, however, saw the York Clinic open for its proper use and serving both military and civilian needs. Gillespie returned to Guy's and his plans for the future began to take shape. It is certain that he had many and that no one knows them all. Immediately in front of him was a proposal to add to the clinical teaching and research facilities of the department the similar resources of the Cassel Hospital in Kent, and so to weld the two together in a mutual professional collaboration. Later, a mental hospital was to be included in this professional partnership which would provide magnificent opportunities for undergraduate and post-graduate experience.

Facilities such as those of the York Clinic were to have been made available for all classes of the community, and many new research projects were to have been undertaken.

His health, which broke down when he was in the R.A.F., after years of unsparing effort, was never fully restored. His death is a tragic loss to Guy's, to psychiatry and to medicine. It is the more poignant because so much for which he had worked had come, or was about to come, to fruition. Of no man could Donne's words be more truly spoken :—" His *death* diminishes *me* ; because I am involved in *Mankind* ; and therefore send not to know for whom the bell tolls ; it tolls for *thee*." C. H. R.

On Superficial Epitheliomata and Chronic Arsenical Poisoning

A Clinical Lecture delivered at Guy's Hospital by L. FORMAN, M.D., F.R.C.P.

GENTLEMEN,—Two cases recently seen showed various types of superficial epithelioma, precancerous changes as well as frank basal-celled carcionmata.

Case 1.—Woman æt. 46 years. Nineteen years ago she commenced to take arsenic and bromide for epilepsy and continued for seven years. Six years ago—*i.e.*, six years after the arsenic mixture was stopped—she noticed the skin changes which have slowly developed up to the present time, when the following lesions were found :—

Below the right armpit a red patch, not indurated, oozing and tending to be crusted over.

On the right leg a raised, fleshy tumour, the size of a Spanish nut, which had become prominent during the past six months.

On both legs numerous scaling areas resembling psoriasis. Above the left tendo Achilles these reddish scaling areas were more raised.

On the palms were numerous dry, warty projections from the skin.

Case 2.—Man æt. 37 years, who many years ago had had arsenic given to him for epilepsy. Ten years ago noticed scaling areas on trunk. When recently examined there were scaling, pink areas showing central atrophy, about ¾ in. across, on the trunk. On the lower abdomen there was a fleshy, prominent tumour. On the palms of the hands numerous prominent warts were found.

Histological examination of the various types of lesions gave an interesting range of findings which could be correlated with the clinical appearances. Thus, in the first case, the dry or scaling areas showed the changes detailed by Goldsmith :—

1. Hypertrophy of the epidermis.
2. Irregularity and disorder in the structure of the epidermis with increased number of cells.
3. Increased number and abnormality of mitoses.
4. Polymorphism of cells, especially of the nuclei which may be clumped, multiple or giant.
5. Dyskeratosis—*i.e.*, abnormality in keratinisation of the prickle cells. The keratinised prickle cells show hyaline degeneration and are seen as round bodies with sharply defined membranes.

The dry, scaling area above the heel, which was more raised, showed a corresponding thickness of the epidermis and greater variety of nuclear change, the appearances resembling those of " Bowen's disease."

The raised fleshy tumour on the leg showed an early keratinising epithelioma, with numerous cells showing the nuclear changes, clumping, and multinuclear formation seen in the dry, scaling lesions. This is an example, therefore, of the transference of the Bowen type of superficial precancerous change to the more clinically obvious epithelioma.

The red oozing patch on the chest wall, recalling clinically Paget's disease, showed, however, under the microscope invasion of the epidermal cells by smaller, darker and more deeply staining cells—cells of the basal layer with a more rapid growth potential, not however breaking through the basal layer; the so-called " intraepidermal carcinoma."

The findings of horny and warty defined thickenings or projections on the palms and palmar aspects and sides of the fingers, in cases of multiple superficial epitheliomata, gives the clue to the ætiology of the latter. They are the cutaneous hypertrophic changes provoked by ingestion of arsenic. Conversely, in all cases of single or multiple superficial epitheliomata, the palms should be carefully examined.

The palmar changes vary from punctate thickenings to large rough, warty projections up to the size of a pea, with a histology showing corresponding range of

changes. In the smaller lesions there is a downward prolongation of the epidermis into the cutis, resembling an ordinary infective wart. In a later stage the changes of epidermal hypertrophy and nuclear change described above are found, culminating in a prickle cell epithelioma with invasive potentialities. Ayres and Anderson report that for a year it was their routine procedure to examine the soles and palms of every case of basal-celled epithelioma seen. Of forty-four cases, three-quarters showed small, discrete, punctate keratoses on the palms and soles.

In a reported series of eighty-five cases the arsenical keratoses of the palms and feet:—In nineteen cases, arsenic had been given for psoriasis; in eight cases, for dermatitis herpetiformis; in eight cases, for eczema; in seven cases, for superficial epitheliomata; in five cases, for psycho-neurosis; in four cases, for syphilis (given by mouth); in two cases, for pernicious anæmia; in two cases, in tonic; in one case, for complexion; in one case, for acne; in one case, for asthma; in one case, for leukæmia; in one case, for Parkinson's; in one case, for chorea; in one case, arsenic in contaminated water supply. In thirteen cases no definite history of ingestion of arsenic. Youngest case was ten years and oldest case seventy-two years. The average age of onset was forty-four years. Arsenical pigmentation was associated with keratoses in about half of the cases.

The amount of arsenic taken and the time necessary to produce the cutaneous triad of pigmentation, palmar or plantar keratosis, and epithelioma is variable. One case was quoted by Montgomery as having taken arsenic for a month twenty years before arsenical keratoses appeared on the palms and soles.

In this series of arsenical keratoses, epitheliomata developed in 20 per cent. of cases either in the keratotic lesions of the palms or as superficial epithelismata elsewhere on the body, and four patients died as the result of metastases.

Experimental proof of arsenic as a carcinogenic substance was given by Leitch, Archibald and Kennaway, who produced carcinomata in the skin of rats by the application of a solution of .02 per cent. of arsenious oxide for several months. Pentavalent arsenic, arsenious oxide, is the arsenical usually given therapeutically by mouth, and is more readily fixed to the skin than is the trivalent arsenic. However, Cannon refers to cases of multiple basal-celled epitheliomata, who had been treated previously with injections of N.A.B.

The ability of arsenic in some individuals, to provoke epithelial hyperplasia, raises the question of the advisability of treating syphilitic leukoplakia of the tongue with organic arsenic by injections. The neoplastic tendency of leukoplakia might be increased by arsenic.

Where arsenic is taken in medicines the ætiology of epithelomata and keratoses is explained, but arsenic may be present in drinking water, or may be inhaled from wall-papers as a result of the action of moulds. Certain occupations entail the risk of absorption of arsenic—*e.g.*, miners and smelters handling copper ores.

The discovery of significant amounts of arsenic in the urine and in the skin, and of arsenic trisulphide crystals in the keratomata of the palm and in epitheliomata, have been described by Osbourne, Montgomery and Ayres.

Arsenic is a protoplasmic poison and is recognised as being able to cause exfoliative dermatitis. It is not unlikely that arsenic is responsible for less widespread cases of dermatitis of unknown origin. Where a dermatitis follows injections of organic arsenic, a very small amount of the drug is capable of provoking a relapse, suggesting a sensitisation to the metal. Blood changes may also follow sensitisation—*e.g.*, purpura, leukopænia and thrombocytopænia. Other manifestations of arsenical intoxication are pigmentation, cirrhosis of the liver and neuritis.

Two cases of cirrhosis of the liver observed were striking. Both were cases of dermatitis herpetiformis. This disease, characterised by an irritable rash and blisters, is, in most patients, controlled by arsenic, but medication has to be continued to prevent relapses. It therefore becomes a choice between the disease and the serious risk of a toxic, and degenerative, visceral change. One case was a woman of thirty-five years, who showed jaundice, pigmentation, and a large, hard liver and ascites. The other patient, aged sixty years, had deep pigmentation, ascites and a hard liver. Both patients had been taking arsenic by mouth over a period of years.

It must be questioned whether it is justifiable to give arsenic, particularly pentavalent arsenic, save where it is indicated in serious and potentially lethal diseases—*e.g.*, syphilis, trypanosomiasis, and spirachætal jaundice. In dermatitis herpetiformis it may be necessary, although other treatments are sometimes as helpful. Arsenic should not be given for psoriasis, save in short, prescribed periods. The prescribing

of arsenic for anæmia and as a tonic has lost favour among physicians. Medical officers should be vigilant and not repeat the prescriptions of out-patients without being fully aware of what is being repeated. Arsenic has been ordered for years for some patients in this fashion. The custom of ordering arsenic with bromide should be discontinued.

Legally there is no reason why a chemist should not repeat a prescription for arsenic as often as it is desired, and prescriptions should therefore be marked "Not to be repeated."

With age the skin generally becomes dry, wrinkled, inelastic and the epidermis tends to be thin. This change is well seen over the exposed parts (the face and backs of the hands) and in those whose occupation leads to much exposure to light—*e.g.*, seamen and farmers, particularly in countries where the light is intense—in South seamen and farmers, particularly in countries where the light is intense, such as South Africa, Australia and South America. Fair complexions suffer most. Pigment absorbs the harmful, short part of the spectrum, and cases of multiple epitheliomata of varied histology on the exposed skin of albinos of dark races have been reported by Hewer. Albinos have a congenital absence of pigment of the whole skin and of the eyes.

Although in the great majority of cases natural sunlight is the cause of the premature ageing of the skin, and the atrophy of the epidermis, and changes in the elastic tissue, prolonged exposure to the light of a mercury vapour lamp may produce the same anatomical changes. Thus Coulquhoun, of Melbourne, quoted by Goldsmith, has observed the development of multiple keratoses on the chest of a man who had been treated with the quartz lamp for eighteen months. The increased use of mercury vapour lamp lighting in industry raises the possibility of an increased incidence of senile keratoses.

The senile keratosis is to be recognised on the nose, the cheeks or the back of the hand as a small scaling area, the scale being dirty, rough and not easily detached. The base may become more raised, indurated and congested, suggesting increased epithelial growth and reaction in the cutis. These signs are indicative of a malignant phase. The senile keratosis shows an hypertrophied epidermis with irregularity of structure and formation of clumped cells and variable sized nuclei. They give rise to epitheliomata of any of the types mentioned—*i.e.*, basal celled, prickle celled and Bowen. According to Goldsmith they are usually basal-celled on the face and prickle-celled on the hands.

A similar atrophic change of the skin may be induced by X-rays or radium. The biological effect of these radiations is to prematurely age the skin. This atrophic change may not develop until some years after treatment has been given. The skin will then show the same dry, wrinkled appearance, with blotches of pigment and telangiectatic vessels. Keratoses are liable to develop and to become epitheliomata, although the tendency to invade and metastasise is not great.

Lastly, there is an important group due to exposure to hydrocarbons, especially to those of high boiling point. The experimental production of carcinomata in animals by exposure to tar has been confirmed over a period of many years. This risk is recognised by law in many occupations—*e.g.*, workers with tar, pitch, shale oil and paraffins. A splash of hot tar on the face may be followed in a few weeks by the appearance of a button epithelioma, a reddish tumour springing abruptly from the skin. The paraffins irritate the skin, causing follicular hyperkeratosis, pustulation and pigmentation. Keratoses and epitheliomata may develop. Where heavy lubricating oils are allowed to remain in contact with the skin and are not removed by washing, or where the clothes become impregnated with oil and the standards of personal cleanliness are low, keratoses and epitheliomata appear—*e.g.*, the cancer of the scrotum in operatives in the cotton industry ("mule spinners' cancer.)" This type of epithelioma was eradicated in the industry when the mechanism of its production was understood.

For a discussion of the subject reference may be made to "Arsenic as an Etiologic Agent in Certain Types of Epitheliomata," by H. Montgomery, *Archives of Dermatology and Syphilis*, 1935, Vol. 32, page 218.

REFERENCES.

Ayres and Anderson, 1934. *Archives Dermatology and Syphilis*, Vol. 30, page 33.
Goldsmith, W. N., 1936. "Recent Advances in Dermatology." Churchill, London.
Hewer, T. F., 1932. *British Journal of Dermatology*, Vol. 44, page 469.
Leitch, Archibald and Kennaway, 1922. *British Medical Journal*, Vol. 2, page 1107.
Osbourne, E. D. 1925, *Archives Dermatology and Syphilis*, Vol. 12, page 77; 1928, *Archives Dermatology and Syphilis*, Vol. 18, page 37.
Cannon, A. B. Discussion, 1935, *Archives Dermatology and Syphilis*, Vol. 32, page 235.

Hyperemesis Gravidarum

By ADRIAN HILL, M.R.C.S., D.R.C.O.G.

"THERE is such a large psychic factor in severe nausea and vomiting of pregnancy that almost any therapy will stop the vomiting. Many years ago we had no commercial vitamins, yet we cured nearly all the cases of hyperemesis just as we do to-day. Sir Arthur Hurst is convimced that the pernicious vomiting of pregnancy is always hysterical. He believes the division into nervous and toxæmic cases is fallacious. All patients are nervous, but the word 'hysterical' should be substituted for 'nervous' for the condition is typically hysterical and curable by psychotherapy. I agree on the great value of psychotherapy, but only in the early stage of hyperemesis. After a woman has lost a great deal of weight, is dehydrated, has a rapid pulse and shows abnormalities in the urine, and perhaps other symptoms such as jaundice, the condition is 'way beyond the stage where psychotherapy can bring about cure. Liquids and nourishment, especially glucose, are important and must be given intravenously in large amounts. Sedatives also must be given. Vitamins are of great benefit, but they are not specific remedies. Of course, it is most important to overcome the nausea and vomiting before the condition reaches the stage where it is 'pernicious' and here psychotherapy is the paramount remedy."

This summary of the present position regarding the treatment of severe pregnancy vomiting, given by Greenhill (1), in the "American Year Book of Obstetrics and Gynæcology for 1944," is quoted because it seems to strike a sensible balance between the view so long held by the late Sir Arthur Hurst (2) (and forcibly reiterated in the *Gazette* as recently as 1943), that such vomiting is entirely a manifestation of hysteria amenable to psychotherapy, and those of others, who postulate more material causes and put their faith in physical treatment. Indeed, it goes further and, without directly contradicting the views of Hurst, does something towards reconciling the two schools of thought in that it suggests, by inference at least, that the so-called toxic signs evident in severe cases may be due entirely to long-continued vomiting which, in its early stages, may well have been hysterical in origin.

The work of Osman (3) pointing out that continuous vomiting from any cause is capable of producing severe extra renal uræmia, lends some support to this theory, which perhaps deserves wider emphasis in present-day teaching, and the following case is recorded in the hope both of adding some slight evidence in its favour and of demonstrating some of the difficulties occasionally to be met with in practice.

It is regretted that conditions then obtaining prevented complete investigation and no claim is made that the treatment accorded shows anything save partial success in a particular case; still less that such psychotherapy as was attempted was necessarily comparable to the irresistible persuasiveness of Hurst (a disappointment shared possibly by many of his imitators).

CASE HISTORY.

Mrs. A. B., a primipara aged thirty-five, was first seen in consultation in a small hospital on May 19th, 1943, on account of persistent vomiting. She was then some twenty weeks pregnant and the vomiting had been severe for about a fortnight. She had had one miscarriage seven years ago and had apparently convinced herself that she was pregnant for several months during 1942, a fact strongly suggestive of hysteria, which was appreciated. Some nasal polypi had been removed during 1942, but otherwise there was no definite history of disease.

Acting on the assumption that an hysterical tendency was, in part at least, a cause of the vomiting, positive reassurance was at once given and an attempt made to convince the woman that the symptoms need not continue, but, in view of her wretched condition of dehydration and starvation, as evidenced by a rapid pulse rate, sunken eyes, dry skin and parched tongue, etc., it was considered wise, both for her sake and that of the fœtus, to restore the fluid balance rapidly by intravenous glucose-saline. Of this 2,000 cc. of a 5 per cent. solution were given during the next forty-eight hours, together with vitamin B1. 25mg. and progesterone 10mg. intramuscularly on alternate days, with luminal gr.$\frac{1}{2}$ night and morning to help in allaying restlessness.

The vomiting lessened immediately and ceased altogether after three days, by which time normal diet was being taken and the patient returned home apparently quite well four days later on May 27th; small doses of vitamin B1. (6mg. b.d.) being continued by mouth.

On June 10th, however, vomiting was resumed and after two days the woman again looked extremely ill, but responded rapidly to a further 2,000 cc. of glucose-saline intravenously, given at home this time, and a satisfactory enema, after which normal diet was offered and accepted.

Thereafter the pregnancy advanced normally; there was no sign of albuminuria or œdema, the maximum blood pressure recorded was 130/90 and there was no jaundice. Reassurance was given at frequent intervals and some pains taken to encourage a sensible attitude towards pregnancy and the forthcoming confinement.

Nevertheless, in spite of all this, severe vomiting began again on July 24th and continued unabated, although all methods of treatment outlined already were instituted.

On July 26th admission to Lymington E.M.S. Hospital was decided upon and a slight improvement followed in that the vomiting lessened and, after forty-eight hours, had almost ceased. An X-ray photograph taken on admission showed a single fœtus of a size suggesting some thirty weeks' gestation and presenting by the vertex. No abnormality of fœtus or pelvis was detected.

Unfortunately, however, the output of urine diminished steadily, despite continuous glucose-saline since admission, and for the first time the urine was found to contain a small quantity of albumen (¼ part per 1,000, Esbach), but no other macroscopic abnormality. Mental impairment followed and, by the morning of July 31st, the woman had passed rapidly through irrational confusion to deepening coma. The fœtal heart, which had been audible on the previous day, could not then be heard; the blood pressure was recorded as 90/60, while a sample of blood for urea estimation gave the high figure of 268 mg. per cent. There was still no jaundice visible.

Thus it seemed certain that whatever in the first place may have been the cause of the vomiting, attempts to cure it by conservative methods had failed and the woman was dying from a rapidly increasing toxæmia, which already had probably killed her child.

To empty the uterus without delay seemed imperative and abdominal section was the method chosen; admittedly a big risk in a woman already exhausted by vomiting and gravely toxic, but any slower method, such as rupturing the membranes, even if combined with hydrostatic or hygroscopic dilatation, seemed futile in the presence of such rapid deterioration, and the occurrence of three severe fits while preparation was being made for the operation seemed to lend some support to this view, although it is well realised that when observing such a catastrophe unbiased decisions are impossible and operative risks easily underestimated in the urgent quest to alleviate symptoms.

OPERATION.

Rapid classical section was performed under ether and oxygen anæsthesia and the intravenous drip, which had been running pre-operatively and had somehow survived the fits, was maintained during operation and the after-treatment.

As expected, the fœtus was dead and showed signs of early maceration, but no other abnormality. The liquor amnii was heavily stained by meconium, but was not offensive, and no macroscopic abnormality was detected in the placenta.

POSTOPERATIVE TREATMENT.

After operation the patient, on account of the fits, was treated on the lines suggested by Gibberd (4), after Stroganoff, for eclampsia: that is to say, the absolute minimum of disturbance combined with sedatives in sufficient does to abolish consciousness, which, in the forty-eight hours during which this was required, amounted to morphia gr. ¾, chloral hydrate and potassium bromide of each gr. 132. During this time no attempt was made to feed the patient, tamper with the bowels or perform any nursing service whatsoever, other than to pass a catheter some sixteen hours after the operation

and thereafter at regular intervals when the effect of the sedatives was most pronounced. Over-emphasis of the policy of non-interference probably caused the first catheterisation to be unduly delayed, for some 52 oz. of urine were then withdrawn, but such diuresis was extremely welcome as a sign of returning kidney function and any distension of the bladder thay may have occurred gave no trouble.

As no further fits (save one very doubtful one four hours after the operation) had occurred at the end of forty-eight hours, the sedatives were discontinued and the woman gradually regained consciousness, a satisfactory diuresis being maintained.

Abundant quantities of fluid were given by mouth, the intravenous drip discontinued, and the patient thereafter treated in the normal manner following abdominal operations with a full diet as soon as she was able to tolerate it. The urine, both from the point of view of quantity and that of abnormal constituents gave no further anxiety and recovery was uneventful, save for some slight superficial sepsis in the abdominal wound, which ultimately healed soundly, and a small subcutaneous collection of pus where a cannula had been inserted above the left ankle. Both these conditions were ascribed in part to excessive perspiration owing to hot weather and to the poor tissue resistance of uræmic patients. The pus above the ankle was evacuated through a small incision on the twentieth post-operative day.

On August 29th the patient was discharged from hospital seemingly very fit and with no abnormality of urine or blood pressure, although a blood urea estimation was still as high as 156 mg. per cent.

During the next month at home improvement continued and by September 27th when normal work was resumed, the blood urea had fallen to 48 mg. per cent. A further estimation some six months later gave a reading of 44 mg. per cent. and at this time the woman appeared to have recovered her usual health, although in her attitude towards life certain hysterical tendencies were still obvious, and it is interesting, and in some ways sad, to reflect that her inability to make the necessary mental adjustment to pregnancy may have been the sole cause of the death of her child and of the danger through which she passed; at least, none of the physical findings, either clinical or chemical, were such as could not be ascribed to profound extra renal uræmia consequent upon long-standing vomiting and dehydration. However, any true assessment of the mental effects of pregnancy is difficult in war-time and, as regards this particular patient, it is only fair to say that her husband was away serving in the army at the time when his influence might have been of the maximum assistance.

SUMMARY.

A case is described of a primipara, aged thirty-five and of hysterical disposition, who was seen suffering from severe vomiting after twenty weeks of pregnancy. On two occasions the vomiting cleared up rap dly after reassurance combined with intravenous therapy, but a third attack at thirty weeks proved resistant to such treatment and resulted in oligura and uræmia with fits and coma. A male fœtus, weighing 4½ lbs. and showing early maceration, was removed by classical abdominal section. Large doses of sedatives were used to abolish consciousness for forty-eight hours, after which diuresis and recovery followed uneventfully save for slight superficial sepsis.

The blood urea at the time of operation was 286 mg. per cent. and was thereafter observed to fall slowly, being estimated at 156 mg. per cent. one month after operation and 44 mg. per cent. five months later.

The total quantity of intravenous glucose-saline used in the course of treatment was 14,700 cc. or, approximately, 28 pints.

My thanks are due to Dr. Mary Edwards, of New Milton, in whose care the case was originally; and to Dr. H. Gleave, pathologist to the Royal South Hants Hospital, who kindly carried out the chemical investigation and gave much helpful advice.

REFERENCES.

(1) Greenhill, J. P. "American Year Book of Obstetrics and Gynæcology, 1944, p. 96.

(2) Hurst, Sir Arthur. *Guy's Hospital Gazette*, 16, x, 43, pp. 225–227.

(3) Osman, A. Arnold. *Guy's Hospital Gazette*, 16, x, 43, pp. 228–230.

(4) Gibberd, G. F. "Short Text Book of Midwifery, 1943."

Correspondence

"A SILENT REVOLUTION."

To the Editor of the GAZETTE.

SIR,—Our attention has just been drawn to Dr. Vertue's witty appreciation, published in your number of October 13th, 1945, of the excellent work done by the late Dr. Cameron. Although we most heartily agree with everything he has written about Dr. Cameron and his work at Guy's, we feel strongly that his derogatory remarks about our countryman, the late Sir Truby King, were most unjust. It is no exaggeration to say that Sir Truby King, whose methods of infant feeding and management have been adopted throughout the length and breadth of New Zealand, was solely responsible for reducing the infantile mortality rate in New Zealand to the lowest in the world.

Dr. Vertue states that much harm has been done to children reared under this "unpleasant doctrine." To this we take the strongest exception, for we know from practical experience that Plunket babies are happy, healthy and contented and, although the system has been in operation in New Zealand for at least thirty years, most people will agree that the rising generation of that country shows no sign of mental or physical degeneration. We would remind Dr. Vertue that Truby King, whom he chooses to describe as a "looney specialist," was knighted by the King for his services to infant welfare and that his name remains an honoured one in New Zealand.

And, finally, although this system was rejected by Guy's and St. Katherine's, we are not prepared to admit that this automatically damns it.

We are, etc.,

J. L. LAURENSON,
J. S. BATCHELOR.

Orpington War Hospital,
Orpington, Kent.

To the Editor of the GAZETTE.

SIR,—As Sister-in-Charge if Salomon's Centre, I would like to support the statement made by Dr. Vertue, in his letter appearing the the *Gazette* a month ago. In my experience, the cases of summer diarrhœa are negligible, and while I do not consider the Borough exactly a health resort, the standard of child as seen at this Centre, is higher than before the War. As regards broncho-pneumonia, this is so rare as to occur only as a complication of a sporadic case of measles.

The Health Visitors, under my tuition for the past four and a half years, have never seen a case of cows' milk atrophy, and the percentage of breast-fed babies attending the Clinic is considerably higher than at any other Centre, as we do not sell dried milk, nor encourage it.

Owing to the habit of deep shelter life cultivated during the "blitz," our mothers developed a sense of security and inevitably adopted a system of breast-feeding, and the children of those days now attending school are some of the best. My observations have led me to notice that it was the evacuated mother who returned from the country with the bottle-fed baby, but that our own ward and district mothers breast-fed their babies in nearly every case.

Is it not conceivable that London might be ahead of Leicester ?

I am, etc.,

L. COOMBE, S.R.M., S.C.M.

Salomon's Centre,
Guy's Hospital, S.E.1.

"PROSTHETIC DENTISTRY."

To the Editor of the GAZETTE.

SIR,—I read with interest your South African correspondent's letter in the last issue of the *Gazette* (November 10th), criticising J. B. K.'s review of the book, "Prosthetic Dentistry," by F. W. Cradock. I have not read the book, but I am

familiar with J. B. K.'s qualifications which, I know, were not awarded without due respect for his knowledge of dental subjects.

It would be interesting to ask Mr. Popper the names of "the most eminent prosthetists" in whose opinion the face-bow is "the greatest advance in dental *metrology since the birth of prosthetics.*" I am sure that even a mediocre prosthetist could say that a face-bow is not necessary "to obtain a three dimensional positional relation record of the *maxilla to the kinematic condylar axis of the mandible* in the rest position." I would go so far as to ask your correspondent whether he fully understands the last phrase himself. In any case, *this relationship is given, I submit,* by the ordinary wax bite-block method used to fix models of the denture bearing tissues to an articulator.

What the face-bow readings are taken for, is to determine the relative positions of the mandible to the maxilla in protrusive and lateral movements of the lower jaw for any given patient. These positions must be dependent upon the path travelled by the head of the condyle of the mandible during mastication. It therefore follows that the inclination of the condylar path to the Frankfort plane can affect the movements of the lower jaw, and it is the duty of an "anatomical" articulator faithfully to reproduce these movements. To say that "the face-bow record has no more bearing on the condylar inclination than it has on the age of the patient . . . . etc." is, I submit, nonsense.

In taking your correspondent's second point into consideration, it seems obvious to me that no articulator (not even the Hanau) can be made to reproduce "the resilient and like effects of all the tissues involved during the masticatory effort." It is surely impossible, for example, for the cushioning effect as a denture sinks into the mucous membrane, and which can materially affect articulation of the teeth, to be reproduced with the aid of any amount of face-bow records. These resilient effects of the tissues must be overcome at the impression stage since they cannot be compensated for on the articulator.

The foregoing points lead up to my submission that to dispense with a face-bow is not to court disaster. Balanced articulation is a very desirable objective, but it can be obtained by other means than that of taking a face-bow reading for every patient. Skilled setting-up of teeth with due attention to reasonable curves of Spee and Monson on good models, correctly assembled on an average anatomical articulator and without the aid of a face-bow, can produce results that are far from mediocre.

I cannot agree entirely with "J. B. K." that a face-bow is better dispensed with in all cases, but from the point of view of good practical prosthetics I would support his views rather than assume that a face-bow record is indispensable to good full denture prosthesis.

In conclusion, Sir, may I ask Mr. Popper if he does not occasionally, and perhaps with a pang of regret, gring his dentures in, too ?

I am, etc.,

P. C. GRUMMITT,

B.D.S.(Hons.), Lond. ; Surg.-Lt. (D.), R.N.V.R.

H.M.S. *Wildfire*,
Sheerness, Kent.

Sport

Rugby

GUY'S *v.* CAMBRIDGE UNIVERSITY.

(*Played at H.O.P., Wednesday, October 24th.*)

Result : Guy's 6 points ; Cambridge University, 6 points.

The first visit of Cambridge University to London this season attracted a big crowd, and they managed to hold the Hospital to a draw, each side scoring a try and a penalty goal.

In the first half Guy's had the elements against them—a strong wind, rain, and at times a strong sun. Nevertheless, they had a fair share of play and, after a gruelling first quarter of an hour, recovered and changed over 3 points all. Cambridge took the lead after fifteen minutes with a good try, H. M. Kinderley taking a return inside pass from J. Fairgrieve, following a run through the middle by T. K. M. Kirby. Near the interval L. Le Clus broke clean through, selling two dummies on the way to give F. van der Westhuizen the easiest of chances for a try near the posts which D. G. Jones failed to convert after "no charge" had been declared.

Cambridge University recovered the lead when T. K. M. Kirby kicked a penalty goa

against the wind from a long way out, but D. G. Jones placed Guy's on level terms in the next minute, also with a penalty goal.

The Hospital had chances to win this game, especially in the closing stages when pressing on the Cambridge line, but the passing out and handling was bad. For the first time this season the home supporters had the mortification of seeing the ball going astray and mishandled, and gone was that crisp and accurate passing to the wings we have grown accustomed to expect.

I place N. K. Macrae-Gibson the best back on the field, always dangerous with some forceful runs, and once saved his side from from a certain try when taking the ball from the feet of two Cambridge forwards on Guy's goal line.

The forwards tackled relentlessly, especially A. Batty Shaw, I. H. Hilliam and A. De Villiers, who always got the man in possession, but the line-out work was crude. D. G. Jones did the right thing in frequently kicking to the Cambridge "25" with the wind, but there the advantage ended, owing to Guy's inability to get the ball from the line-out or the scrums.

The forwards still persist in dribbling through after the first check, when it would be more advantageous to heel and give the backs an opportunity of rounding off the movement.

GUY'S *v.* ALDERSHOT SERVICES.

(*At H.O.P. on Saturday, October 27th*, 1945.)

Result: Guy's, 16 points; Aldershot Services, 18 points.

The Hospital were most unfortunate in losing to Aldershot Services by 3 goals and a penalty goal to 2 goals, a try and a penalty goal.

The penalty goal against Guy's came at a crucial stage of the game and was, no doubt, the turning point. P. J. Dwyer appeared to touch-down correctly over his own line following an Aldershot rush, and having done so picked up and kicked to L. Le Clus waiting under the goal-posts to take the drop-out. The referee then ordered a penalty kick against Le Clus for off-side, much to the surprise of players and spectators who thought the decision harsh, and after the game the referee gave as his reason that P. J. Dwyer had not touched down correctly.

Even so, 16 points should be sufficient to win most games, and the fact that the Services crossed the Hospital line three times indicates a weakness in defence. It was so. As against Cambridge University, so against Aldershot, the opposing stand-off half was allowed too much scope, and it was here the damage was done. We shall be meeting some powerful half-back combinations during the season and if nothing is done to prevent the opposing stand-off half breaking through one can visualise a lot of trouble.

There was little wrong with the forwards apart from tackling high and still not reaching for the ball in the line-outs, but the three-quarters were completely out of touch with each other, though F. Van der Westhuizen tried valiantly to improve matters, but he was too well marked to make those judicious runs through the middle which has been a characteristic feature of his play.

The absence of N. K. Macrae-Gibson and D. G. Jones undoubtedly affected the back play; and D. N. H. Owen, the Cambridge war-time Blue, did not have a single chance of showing his worth on the wing.

Guy's took an 8-points lead with a penalty goal by F. Van der Westhuizen, who also converted a try by P. J. Dwyer. The Services then scored 18 points with tries by Corporal Cross, Lieut.-Col. Rush and Sergeant Rogers; and the penalty goal was kicked by Lieut.-Col. Campbell, who converted all the three tries. P. J. Dwyer reduced the lead before the interval with an unconverted try. The only score in the second half being a try by P. S. Carton-Kelly, which F. Van der Westhuizen converted.

Rowing

GUY'S *v.* MIDDLESEX HOSPITAL.

This was held on Saturday, October 27th, 1945, and resulted in a win for Guy's by one-third length. The rowing was hardly up to the best standard of either crew, but the departure of many of the Middlesex men for the Rotunda made it necessary to hold the race before the end of October. The race was rowed over a short course and from the start developed into a mad sprint in which Guy's were able to take a short lead in the first ten strokes. This was nearly lost after the first minute, but a few "10s" sufficed to bring the Guy's crew past the post ahead of Middlesex.

Hospital Information, etc.

Pass List

CONJOINT BOARD.
FINAL EXAMINATION.
October, 1945.

Pathology.

A. G. Atkinson — H. Herbert
I. A. Blackmore — C. D. Korn
D. W. J. Cullingford — T. N. Reynolds
J. F. Delafresnaye — R. E. Sidebotham
T. R. L. Finnegan — M. D. Warren
J. J. Fingard

Medicine.

*E. R. Arnold — *J. D. Huntley
L. W. Bowen — *R. R. W. Nichols
*E. C. Davies — *C. M. Ruben
W. M. C. Hallinan

Surgery.

D. W. J. Cullingford — H. A. R. Loxdale
D. J. Dennison — *D. O'Keefe
M. M. El-Shinnawi — *C. M. Ruben
*F. F. Jerichower

Midwifery.

W. W. Cree — *F. F. Jerichower
D. W. J. Cullingford — H. A. R. Loxdale
*E. C. Davies — J. Lederer
*S. Davis — F. W. R. Seward
*J. Fifield — G. R. Wotton
K. E. Jefferson

UNIVERSITY OF LONDON.
THIRD (M.B. B.S.) EXAMINATION FOR MEDICAL DEGREES.
October, 1945.

Honours.

*J. Luder

* Distinguished in Medicine.

Pass.

K. D. Allanby — J. W. Lewis
D. E. M. Brown — P. R. Montgomery
K. A. A. Campbell — C. R. Neve
K. H. Chin — P. F. New
A. R. Darlow — K. A. Newton
S. Davis — D. O'Keefe
G. E. Griffiths — J. M. Pugh
J. D. Huntley — C. G. Roberts
R. G. G. Jones — J. F. Shaw
T. J. Jones — F. R. M. Young
M. B. King

PART I.

G. F. Barnes	R. V. H. Goulder
A. G. Bearn	J. G. P. Hutchinson
K. W. Bolt	S. L. O. Jackson
D. F. V. Brunsdon	C. L. Joiner
M. B. Conran	P. A. W. Lea
D. W. J. Cullingford	L. V. Martin
D. G. L. Davies	T. N. Reynolds
A. E. Doyle	G. M. Ruben
J. J. Fingard	R. G. Watson
T. R. L. Finnegan	J. M. Wilks

PART II

P. E. Brown	P. A. W. Lea
T. G. Hooson	G. F. Penny

PART III.

W. F. Belsham	R. Owen
P. Coling	R. A. Parker
J. C. Crook	C. M. G. Pearson
J. R. Dickson	C. S. Shaw
H. G. Dixon	B. E. R. Symonds
W. P. Gurassa	G. I. Tewfik
†T. Koonvisal	P. Westcombe
L. V. Martin	J. M. Wilks
T. E. Norman	

† External Candidate.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

F.R.C.S.

PRIMARY EXAMINATION.

October, 1945.

A. Brown — R. G. Robinson
C. O. Fung-Kee-Fung

SOCIETY OF APOTHECARIES OF LONDON.

FINAL EXAMINATION.

August, 1945.

Surgery.—*R. G. G. Jones, D. D. Forbes.
Pathology, Bacteriology and Forensic Medicine.—J. C. Matthews.
Medicine.—B. H. Pickard.
Midwifery.—D. D. Forbes, R. C. Jennings, R. G. G. Jones.

PRIMARY EXAMINATIONS.

October, 1945.

Materia Medica, Pharmacy and Pharmacology.—B. M. H. Bickmore, K. Y. Khong.
Anatomy.—R. D. Walsh.
Physiology.—W. G. Burrill-Holmes.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

L.D.S.

FINAL EXAMINATION.

October, 1945.

PART I.—Surgery.

C. D. Baker	V. H. T. Jekell
J. F. Bowes	G. J. Marks
L. D. Carton-Kelly	F. M. Scherkel
S. Cripps	J. C. Schofield
J. F. H. Flanders	P. G. Shingler
R. Freeman	P. B. Smith
R. G. Iliffe	E. M. Sycamore

PART II.—Dental Surgery.

J. E. E. Attale	V. H. T. Jekell
C. D. Baker	J. B. Kirkwood
C. C. Bull	P. C. Matthews
J. R. Burt	D. J. Reid
S. Cripps	A. G. Starte
D. J. Gray	P. M. Stephens
G. Henry	P. S. Sutton
I. H. Hilliam	I. D. L. Thomson

ROYAL COLLEGE OF PHYSICIANS LONDON.

M.R.C.P.

October, 1945.

A. J. Shillitoe, M.B.,(Lond.).

Guys Hospital Medical School

PRIZE EXAMINATIONS, 1945.

The following awards have been made:—

Leonard Lubbock Prize for Clinical Pathology.
W. E Evans .. Prize.
G. A. K. Missen .. Certificate.

Beaney Prize for Pathology.
C. L. Joiner .. Prize.
G. A. K. Missen .. Certificate.

Golding Bird Medal and Prize in Bacteriology.
A. J. Beale .. .. Medal and Prize
R. V. H. Goulder .. Certificate.

Golding Bird Medal and Prize in Obstetrics and Gynæcology.
J. Luder .. .. Medal and Prize.
K. D. Allanby .. Certificate.

Treasurer's Medal and Prize in Clinical Surgery.
C. S. Shaw .. .. Medal and Prize.
J. C. Crook .. .. Certificate.

Treasurer's Medal and Prize in Clinical Medicine.
K. D. Allanby .. Medal and Prize.
N. B. Finter .. Certificate.

E. R. BOLAND,
Dean.

Change of Address

S. Bockner, Captain, R.A.M.C., and V. Bockner, Captain, R.A.M.C., 35th B.G.H., S.E.A.C.

F. K. Escritt, Brigadier, Medical Branch H.Q., 1 Corps District, B.A.O.R.

C. D. Farris, M.R.C.S., L.D.S., c/o H. Curtis, Esq., Devonshire House, Regent Street, Cambridge.

H. W. A. Post, M.D., 121, Harley Street, W.1. (Tel.: Welbeck 6818.)

Eric Smith, Lieut.-Col., R.A.M.C., 64th (Br.) General Hospital, C.M.F.

Gavin Thurston, M.R.C.P., Elderfield, Hutton Mount, nr. Brentwood, Essex. (Tel.: Brentwood 231.)

Eric Wright, M.B., B.S., St. Aaron's, Caeleon, Mon.

Marriages

BRUCK—WIDLAKE.—On October 25th, 1945, at St. Paul's Cathedral, Calcutta, Lieut. H. E. Bruck, son of Mr. and Mrs. E. Bruck, of Somerset, to Joan Widlake, Q.A.I.M.N.S.R., elder daughter of Mr. and Mrs. J. H. Widlake, of Hither Green, London.

DOUGLAS—MORETON.—During October, 1945, in Calcutta, D. M. Douglas, Sqdn.-Ldr. R.A.F., to Una Moreton, T.A.N.S.

HAWKINS—FANTES.—On September 22nd 1945, at Sevenoaks, Kent, Clifford F. Hawkins, to Susan Fantes.

SMITH—KINNES.—On September 26th, 1945, at Falkirk, Eric Smith, Major, R.A.M.C., to Margaret Airlie Kinnes.

Births

BROWN.—On October 6th, 1945, at Princess Christian Nursing Home, Windsor, to Kathleen (née Long), wife of J. W. Brown, Captain, R.A.M.C.—a son (James Maxwell Victor).

Deaths

DUCHESNE.—On November 9th, 1945, after a short illness, Rupert Leslie Duchesne, L.D.S., R.C.S., of Warwick House, Minehead, Somerset, aged fifty-three years.

EDS. {M.G.T. J.M.H.

GUY'S HOSPITAL GAZETTE

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1497 *8th December, 1945* *Ninepence*

PASSIM

THE *Gazette* has, at present, a circulation of approximately 3,000 copies. Many Hospital readers may not realise that at least two-thirds of the copies leave these offices every fortnight to be distributed to old Guy's men in all parts of this country and the world. For many, especially those abroad, the *Gazette* forms their sole link with life at Guy's. Part of our editorial policy, therefore, has always been an endeavour to produce for them a picture of the Hospital as we know it at present. And in this respect we hope we have not altogether failed.

It seems regrettable, however, that so large a proportion of our readers should obtain so little representation in these pages and suggestions have often been made that some space be devoted to noteworthy news about old Guy's men, their whereabouts and activities. The idea is an admirable one and would be practicable were it not for the ever-present bogey of paper shortage. At the moment this means that only matter of high priority can occupy the available space. We refer to such features as the clinical articles and "Hospital Information."

Although it may be some time yet before the *Gazette* assumes its pre-war size, there is reasonable hope that a slight increase in paper supplies may occur in the near future. In view, however, of the present excess of demand over supply, it has been agreed that the extra paper should go to satisfy this demand rather than to increase the size of the *Gazette*.

We must therefore regretfully abandon the "Old Guy's Men" column for the present, and hope that it may come into being as soon as possible in the future.

A NOTABLE event is included among the forthcoming programmes of the B.B.C. On Sunday evening, December 16th, 1945, the Guy's Student Singers are taking part in the Variety Band-Box feature of the Light Programme. This enthusiastic body, under the direction of Mr. Peter Campion, was recently granted an audition by Mr. Leslie Woodgate, the B.B.C. Chorus Master, who approved and appraised. This broadcast is the result.

WE include this note sent to us by the organisers of the Landon Tea Fund, and hope that its publication will result in a generous response:—"We are hoping this Christmas to entertain the children of the Borough on the old pre-war scale. Realising the present position with regard to supplies, we may have to omit the gift of a toy to each child, but we hope instead to give them a good tea to the strains of a pre-war band. Many old Guy's men have vivid recollections of the way in which the children enjoyed the Landon Tea, and many will wish to help us to meet the necessary cost. Donations should be sent to the Sister-in-Charge of the Out-patient Department, or to the Clerk to the Governors, Guy's Hospital, S.E.1, marked "Landon Tea Fund," and will be very gratefully acknowledged."

THE letter by Messrs. Laurenson and Batchelor, which appeared in the last issue of the *Gazette*, contained an error. They referred in it to "the late Dr. Cameron." We should like to apologise for our oversight in failing to correct this, and for the inconvenience caused to Dr. Cameron, his family and friends.

MR. G. S. LODER has come back to Guy's, and we feel sure that his return will be welcome news to the Dental Department.

WE are sorry to announce the resignation of Mr. Martin Thorne from his post as Editor of the *Gazette*, and we extend to him our good wishes for the future.. At the last meeting of the *Gazette* Committee Mr. Rodney Long was appointed the new Assistant Editor.

Life and Literature

By T. B. LAYTON, D.S.O., M.S.

The Second Presidential Address to the Students' Union.

IT is a year to-day since I left Guy's to join U.N.R.R.A. and to-day I cease to be a member of that association. I have had in that time a belated wander-year, during which I have seen much and have had much food for thought, and much time in which to think it. I was sorry to make the break from those with whom I was working, but having made it, I am glad to be back at Guy's and especially to give to you the second annual address as your president. For it is of you that I want to talk, not of myself. For you are starting at a unique period in the history of medicine, and that for three things. In the first place the total number of medical men and women needed ni the service of the people and of the State has greatly increased. The country is putting into effect the aim that it has had before itself for over twenty years—that every person in the land shall have his or her own family doctor to whom they can go in sickness or in trouble. Then the Act that took the hospitals out of the hands of the guardians and directed that they should be developed for the use of all is beginning to take effect, and this needs a great increase of doctors of all sorts in our hospital service. In addition, there is the development of industrial medicine. We have reached the stage where we can foresee what some of us have been dreaming of for so long—an industrial system in which every place of employment will have a M.O. concerned with personal and local preventive medicine just as is the regimental M.O. in the Forces. In the second place, you are beginning when, in th words of Wilfred Trotter, "it is no longer possible to conceal the wholly unique importance of medicine for the very existence of social life," and as you take on these duties you must be prepared to have a greater command of social prestige and higher privileges than we have had till now. You must fit yourselves so that you are less exposed to exploitation and to criticism, and I hope that you will be less hard-worked and be given more leisure for this purpose of self-development.

Lastly, you will be starting the practice of our profession under the new ideal that is shortly to be put into action. In this you will be fortunate, for you will not have started under the old. You will not, therefore, have that switch over that those who have started under it have to face, with their being used to it, having acquired commitments under it and, to some extent, acquired a love for it. Its tradition was that you took what you could from the rich in order to enable you to treat the poor for nothing. This was the basis of the old domiciliary treatment as well as institutional. It suited the middle of the nineteenth century, which converted the Pauline idea of charity into a financial one; but it had been breaking down since about 1890, and between the wars had become foreign to all ideas and ideals in modern thought. Under the new medical dispensation you will see your patients because they are sick human beings without reference to their pockets, their education, their ancestry or their social position.

You have a great responsibility before you; we, your teachers, cannot fit you for this. That you must do yourselves. We can teach you medicine; but in that wider part of life we can but occasionally give you general guidance, and the annual address to a students' union may be such a one. Let me try firmly to fix in your mind the dual nature of your purpose—the professional and the something more. It was well put in the "Brains' Trust" a month ago by Senhor Salvador de Madariaga from Portugal, when he said: "He who is 'nothing but' is 'not even.'" If you become nothing but doctors you will not even be medical men. I want to put it to you that in the avoidance of this dreadful state, and in your development of this dual personality, the practice of literature takes a foremost place. Do not from this think that I want you to take up nothing else. You have to-day a far wider life than we had when I came up in the reign of Queen Victoria. You have the motor-car and electric trains which take you about quicker than we could go. You have the pictures and the suburban or local theatre and music-hall. You have the wireless and the gramophone. In one thing you are immeasureably above us—that is, in your love and knowledge of music. Hold on to this as hard as you can. But, in spite of all this and in addition to your games, I would urge you always to have a book of secular as distinct from professional reading. Without wanting to put a powder in your jam, I want you to learn subconsciously things that will help you in your professional career; and I believe that literature will do this in a way that nothing else can.

Let us first take poetry. The poets are great observers and they know how to choose their words, and you must do both these things to become clinicians. They are quite distinct; some by nature are better at observing, some at describing what they see. But it is not much good being a good recorder if you have only seen one-half of what there is to see; and remember you always have to record, even though you do not write it out you do so to yourself. Read poetry now that you are still young. It is an almost constant rule that as we grow older we read less poetry, and what we turn to is what we have loved in youth. Therefore it is you who are young that are sorting out the poetry of to-day and deciding what will last. Further, the more you have learnt to love, the more you will have to turn back to in advancing years. To this rule there is, I think, one exception—"Paradise Lost"; but that was the product of advancing years; so do not be ashamed if you have read none of it before you are forty; you may then get all the more out of it.

Read and re-read the great behaviourists of the last two centuries—the English novelists. These will tell you how men act and do. You will then check these descriptions with what you see in the men and women around you. To be clinicians you must not only know quite a lot of anatomy, physiology and pathology, and to be able to observe and to record; you must also be able to interpret the actions and to understand the speech of your patients. For this you must mingle with all types of people; but to help you in these interpretations of your text-books you must go to the novelists from Sterne or before, to Priestley and Howard Spring, and after them to Norman Collins and others. Your great difficulty will be selection. There you are at a disadvantage over us because so much good stuff has been written since I was your age, and you have to get some idea of these in addition to what I had surveyed at that age. Again, you and you only can decide what is good in what is being published to-day, and on your decision will depend what shall live. It is therefore impossible for you to read as much as we had of the older writers. And yet I would not ask you to take our advice, but to make your own selection. Time has decided for you as to certain things. Just as no one would disagree with the statement that the Sistine "Madonna," Rembrandt's "Mother," and Michelangelo's "Pieta" in St. Peter's are three of the greatest works of Art in the world; so all must agree that "Vanity Fair," "Pickwick" and "Tess of the D'Urbervilles" are three of the greatest English novels. But if you do not like any of these put them down and try something else by the same authors. There are those that put "The Newcomes" or "Esmond" above "Vanity Fair"; others who prefer "David Copperfield" or "Bleak House" to "Pickwick"; while I like "The Mayor of Casterbridge" and "The Woodlanders" better than "Tess." In the same way, if you do not like an author after a reasonable trial put those works aside. I cannot stick Jane Austen, and Meredith is meaningless to me.

In the reading of novels you also learn to distinguish those descriptions that are unreal to those that are real. I find both "Jane Eyre" and "Wuthering Heights" to come into the former category, and I believe it is because these young women had had so narrow an experience of human beings.

Of all our English novelists one is, I believe, of more use to us as doctors and will be longer read than any other—and that is Charles Dickens. I do not say he is the greatest. I put both "Tristram Shandy" and "Vanity Fair" above any of his works. I have re-read the "Forsythe Saga" and "Over the River," and I cannot say that of six volumes of any other novelist; but I believe that he will live because he was from the people and of the people, and remained so to the end, however much he hobnobbed with dukes, dined with financial magnates, artists or actors. And he is the greatest scene-painter of them all, with the little sketches that tell how men and women live, just as in an old Italian or Dutch master you can look past the portrait of St. Jerome or other saint and see, through a window at the back, the life of the people of the land in which they lived.

But though he was a great scene-painter I believe his drawing was accurate only of static things, and when he came to movement he was at fault. You have to turn to Conrad for the best dynamic description in English novels. This idea has, however, only recently come to me; I doubt whether I shall still have time to check it. I leave it to you to find out.

If the novelists tell us what men are, biography tells us what they have done. In reading biography we have a great difficulty. Wilfred Trotter has taught us that there is no such thing as an impartial judgment. The emotions always come in and influence it. This is particularly so of biography. The first biographies of great men are written by those that knew and loved them. Then came the memoirs of those that knew;

but did not love them. Then came the second biographies of those that want to criticise, or to debunk, and to raise an impartial monument. The first two are suspect from the start; the third tend to hero-worship their subject and produce a tasteless dish. And yet I would urge you to follow Disraeli's advice and read biography, under which I would include memoirs. You cannot expect to be great, but you may be warned to escape the great man's failing.

Of history and travel I would have you read much. Remember that of the past, the present, and the future, the present alone is unimportant. It has gone before you have time to appreciate its presence. Your business is with the future; the more you know of the past the better you will be able to plan for it. Until you can know of England by leaving her you can only know of her by reading books of travel. This is particularly important in our profession. Diseases of England are so few, so easy, and so tractable, compared with those of the whole world. This has for you entirely a theoretical value, but also a practical one. I do not believe in our attempting to teach you anything about Continental or tropical disease in your undergraduate period; but I do beleve that we should give you an insight into the smallness of pathology in our country. Smuts, who is, I believe, the greatest man living to-day has pointed out how Britain is no longer a wealthy nation, but a poor one; because we have put our last halfpenny into this war. But he added that that was no reason why we should not still be great; and that there was much for us to do in other parts of the world. I do not think it good that we English should leave so much of this to our Northern brothers, and believe that we have characteristics that may set off their greater administrative efficiency; and I would ask you all to consider whether your life's work may not be overseas. I do not ask you to decide at once, but to fit your mind for it by reading books of travel, including modern geography.

Finally, there is criticism. When does ravenous reading turn to the practice of Literature. I believe it is when you start on criticism. In my day this was when we began to argue whether Tennyson or Browning was the greater poet or Thackeray or Dickens the greater novelist. To-day the discussion may be between Arnold Bennett and Galsworthy or from W. H. Davies to W. B. Yeats. If you have started this, continue it; but, if you have not, never fear. Criticism ebbs and flows. Between the wars there was much good editing, which is very valuable, but very little criticism. To-day criticism has begun to flow again with good stuff on Shakespeare, on Milton, and when we in England start on these we are bound to flow out into those others to whom these two mean so much, and between the two of them that is everyone. So if you are interested in criticism follow this fount that has begun to flow; if you are not—never mind, there is plenty for you to read.

One thing never say: that you have no time for it. Everyone has ten minutes a day. At the end of a week that is over one hour. At the end of the year it is two days and a half. During that time you can read quite a lot, and at the end of the year you will find that you have more time to spare than that ten minutes.

So far I have been speaking to you as medical students; now I want to do so as citizens of a new world. Some fifteen years ago I heard a distinguished physicist say that so great had been the development of physics of recent years that it would be a good thing if no single other fact were discovered in the next fifty, and that we should spend that time in learning to use what we already know. Now the distance between knowledge and use is still greater; and we know we cannot stop physicists and other scientists from acquiring new knowledge. Man has got to attain to a higher morality or to disappear, and you are the people to do it. It is not a question of morals in the ordinary sense; but we have fallen somewhat in some way. Perhaps it is that our code no longer fits our way of life. Mr. Priestley* has described it as: "There was no wickedness but only a vast suffocating silliness" and goes on to say: "The fact is that modern man is troubled by a kind of conscience that did not worry his great-grandparents." It is up to you to bring the code of the conduct of life to the conscience of this modern man. Our generation may have allowed the lag to lengthen. It is no good your throwing stones at us for that; but it adds to the truth that we cannot help you in it. We can teach you clinical medicine; we cannot teach you how to reach this higher code. In doing this there is no need for gloom on your part. Quoting Mr. Pristley again: "You cannot be happy long when you are surrounded by people who are obviously unhappy." And, amending him, you cannot make happy the unhappy if you appear unhappy yourself in an atmosphere of gloom. There is room, as Gilbert Murray† said some years ago, for the laughing philosopher. And with these words I say to you, "Go to it."

* "Out of the People," pp. 26, 27.

† "Aristophanes." A Study. Preface.

Lesser Known Guy's Notables:

CHARLES TURNER THACKRAH, 1795–1832

By G. PAYLING WRIGHT, D.M.

IF a man's importance be judged by the influence that he has had upon his own and later generations, Charles Turner Thackrah is the most significant figure that Guy's has yet produced. At the time when England was leading the world in inventions and new industrial methods, Thackrah spent much of his short but very active life in studying the diseases that followed in their wake, and which decimated the populations of the rapidly growing manufacturing cities of Northern England. His book, entitled "The Effects of the Principal Arts, Trades and Professions, and of Civic States and Habits of Living, on Health and Longevity" was the first treatise of any kind to be written in England on this important branch of Medicine. One earlier book—the well-known "De Morbis Artificum" of Ramazzini, a Professor of Medicine ar Padua—had preceded it, but for comprehensiveness, first-hand clinical experience and constructive proposals for improvements, Thackrah's monograph is much superior to the earlier Italian one. Unlike the latter, too, it attracted great attention from both medical men and laymen at the time that it appeared, and there is no doubt that it played an important part in stimulating the factory and health legislation which mitigated some of the worst featutes of the Industrial Revolution.

Thackrah was born in Yorkshire in 1795 and, like most men entering the medical profession in those days, he began as an apprentice to a prominent local practitioner. Again, like the more ambitious of his comtemporaries, he came to London, then the only serious centre for medical education in England, to complete his training in one of the larger hospitals. At that time the clinical staff at Guy's was the most active centre of research in London, and through their publications they were gaining both a national and international reputation for their hospital. Sir Astley Cooper, his immediate teacher and the inspirer of much of his work, was at the height of his powers; while Bright, Addison and Hodgkin, who had all been attracted to Guy's shortly after their graduation at Edinburgh, were his contemporaries. Thackrah remained in this stimulating atmosphere for several years as one of Sir Astley's assistants, and during that time gained a valuable prize that his chief had offered for competition to his dressers for the best essay upon "The Blood." This essay was later published by Thackrah, and he was engaged on a second edition of it at the time of his early death.

After leaving Guy's Thackrah returned to Yorkshire, and settled in practice at Leeds. In 1826 he opened the "Leeds School of Anatomy," which soon became so successful that it grew into the complete medical school from which the present Leeds University School of Medicine has developed. Thackrah may thus be regarded a one of the founders of provincial medical education in England, and as one of the vigorous and successful opponents of the claims to monopoly which had long been maintained by the two Royal Colleges in London.

What directed Thackrah's interest to industrial diseases is not clearly known. It seems likely that it resulted from some personal contact with the famous mill-owner and political reformer, Robert Owen. Owen certainly visited Leeds during Thackrah's apprenticeship to study the methods of working of the local factories and the condition of their employees, and the two men exchanged views at the time. Most probably Thackrah's interest in the medical aspects of the problem were the combined result both of his own professional activities amongst the poorer classes in Leeds and of Owen's forceful representation of the urgency of reform, for the evils of uncontrolled factory development were becoming every day more evident. Whatever might have been the impetus, the results of his activities materialised in a small volume which appeared in 1830, and which was soon followed by a much larger and definitive second edition in 1831, a year before his death. His own intentions in publishing the book may be learned from the two following paragraphs:—

> "The object of this paper is to excite the public attention to the subject. Myself and my pupils have personally and carefully inspected the state of the artisans in most kinds of manufacture, examined the agencies believed to be injurious, conversed on the subjects with masters, overlookers, and the more intelligent workmen, and obtained many tables illustrating the characters of the disorders prevalent in the several kinds of employ. It will be remembered

that the subject is new . . . I have had therefore to enter a new track without guide or assistance."

"Most persons, who reflect on the subject, will be inclined to admit that our employments are in a considerable degree injurious to health: but they believe, or profess to believe, that the evils cannot be counteracted, and urge that an investigation of such evils can produce only pain and discontent. From a reference to fact and observations I reply, that in many of our occupations, the injurious agents might be immediately removed or diminished. Evils are suffered to exist, even when the means of correction are known and easily applied. Thoughtlessness or apathy is the only obstacle to success."

The book is divided into four sections which deal successively with Operatives, Dealers or Shop-keepers, Merchants and Master Manufacturers and Professional Men. Much the longest and most interesting section deals with the Operatives: the manufacturing activities of Leeds at that time, as to-day, were very varied, and the hygienic conditions peculiar to 128 trades and occupations are separately considered. The reason for such a diversity of mauufactures was, as the Hammonds have pointed out, that Leeds, like certain other northern cities, was not the creation of the Industrial Revolution: it was a town of antiquity already renowned as the cente of special industries and trades. Such a town was not thrown up by the Industrial Revolution, but rather overwhelmed by it; its population increased from 60,000 to 130,000 between 1801 and 1831.

Before proceeding to diseases associated with particular trades, two of the more general of Thackrah's comments deserve attention: the employment of children and the frequent references to bad occupational postures as sources of disability. The severity of the conditions of child labour, especially in cotton mills, had been lessened at the time Thackrah wrote, but that they had been far from eliminated can be seen from his comments upon work in the flax mills. "Children from seven to fifteen years of age go to work at half-past five in the morning, and leave at seven in the evening—or at half-past six and leave at eight—and thus spend twelve hours a day, for five or six years, in an atmosphere of flax dust. Serious injury from such employment, we should expect at any age, but especially during the period of growth." "The employment of young children in any labour is wrong. The term of physical growth ought not to be a term of physical exertion. Light and varied motions should be the only effort—motions excited by the will, not by the taskmaster—the run and the leap of an unshackled spirit. How different is the scene in a manufacturing district! No man of humanity can reflect without distress on the state of thousands of children, many from six to seven years of age, roused from their beds at an early hour, hurried to the mills and kept there, with an interval of only forty minutes, till a late hour at night: kept, moreover, in an atmosphere impure, not only as the air of a town, not only defective in ventilation, but as loaded also with noxious dust. Health! Cleanliness! Mental improvement! How are they regarded? Recreation is out of the question. There is scarcely time for meals. The very period of sleep, so necessary for the young, is too often abridged. Nay, children are sometimes worked even *in* the night!" Thackrah's disclosures were not without beneficial effect, for, as Sir Thomas Legge has since stated, the conditions which he described as to the employment of children and their hours of labour, focussed attention on the subject and led to subsequent legislation.

Bad posture at work, though by no means confined to the textile trade and its various branches, was particularly prevalent amongst persons following such occupations. It was probably the large numbers of such tradesmen in Leeds in his time that drew Thackrah's attention the more forcibly to the disabilities and deformities that resulted from it. Weavers, burlers, cloth-drawers and, especially tailors, are remarked upon unfavourably. "We see no plump and rosy tailors: none of fine form and strong muscle. The spine is generally curved. Pulmonary consumption is also frequent." And here, as in most parts of his book, Thackrah is anxious to introduce preventative and remedial measures. "Let a hole be made in a board of the circumference of the tailor's body, and let his seat be placed below it. The eyes and the hands will then be sufficiently near his work: his spine will not be unnaturally bent, and his chest and abdomen will be free."

Of specific industrial diseases Thackrah has much to write, but for us to-day perhaps the most interesting are those now generally grouped under the title of "silicosis." This condition must have then been common in the vicinity of Leeds, and as to-day chiefly affected miners and grinders of metal. Particularly interesting in view of

modern preventative methods are the following observations. "In the mines in the North of England, the workmen, I am informed, suffer considerably when employed in ore in the sandstone, but are sensible of no inconvenience where the ore is in limestone. I am indebted to an intelligent friend for the following information: The reason they assign is, that the latter is full of vertical and other fissures, which allow the superincumbent beds of water to percolate through the roof of the mine: whilst the sandstone strata, which are impervious to water, preserve the mine quite dry; consequently, the minute particles of rock formed by blasting or the pickaxe, are kept in a dry state within the sandstone mine, forming, as it were, an atmosphere of dust, which the miner is constantly inhaling." "Miners rarely work for more than six hours a day, yet they seldom attain the age of 40." "A parallel case to that of the miners occurs in the grinders of Sheffield. Dr. Knight, in the North of England *Medical Journal*, states that the fork-grinders, who use a *dry* grindstone die at the age of 28 or 32, while the table-knife grinders, who work on *wet* stones, survive to between 40 and 50." In both trades, mining and grinding, Thackrah comments on the common association of dust inhalation and tuberculosis. Amongst the men filing the sandy exteriors of iron castings, too, pulmonary diseases were prevalent, and to protect such workmen he recommends, in addition to proper ventilation, the introduction of suitable magnetic mouthpieces.

Amongst other specific industrial diseases discussed by Thackrah, perhaps the most important were those associated with chronic lead poisoning amongst house-painters and the potters making glazed ware. Such men were frequently attacked with colic, suffered greatly from constipation, and ultimately developed the now well-known paresis. Although the signs and symptoms of lead-poisoning were known long before Thackrah's time, he is the first to make specific recommendations for its elimination as a trade disease amongst pottery workers. "Could not the process be effected without the immersion of the hands in the metallic solution? Or could it not be effected by a machine? Or could not some article less noxious be substituted for the lead?" "I am told, indeed, by an intelligent manufacturer of earthenware in Leeds, that the comparative cheapness of the leaden glaze is the chief recommendation. Surely humanity forbids that the health of workmen, and that of the poor at large, should be sacrificed to the saving of halfpence in the price of pots." "The total disuse of lead in glaze is highly desirable."

Thackrah's work in the field of occupational hygiene has never failed of recognition amongst the steadily-increasing number of investigators in this branch of Medicine. He was personally a vigorous, pertinacious and courageous man, who was determined that his findings should be made widely known at a time when the advocacy of reforms was even less popular than usual. The publication of such a volume from a member of the medical profession, with the prestige that special technical knowledge gave him, considerably aided the parliamentary advocates for the limitation of factory abuses.

In conclusion, it may be interesting to record appraisals of Thackrah's position in the history of Medicine by two eminent men who have worked actively in the field which he first prospected. Sir John Simon, the first Chief Medical Officer to the Local Government Board (now the Ministry of Health) wrote: "This special service of investigating health in various branches of industry, Thackrah set himself to render: not under any official obligation or inducement, nor with any subvention from Government, but as his own free gift to a public cause." "Not less meritorious than the assiduity and the care for truth with which he collected his facts, were the unprejudiced good sense and moderation with which he weighed them; and the service thus rendered by Thackrah deserves grateful recognition. By his eminently trustworthy book, he, more than fifty years ago, made it a matter of common knowledge, and of State responsibility, that, with certain of our chief industries, special influences, often of an evidently removable kind, are apt to be associated, which, if permitted to remain, give painful disease and premature disablement or death to the employed persons." Much more recently Sir Thomas Legge, a former Senior Medical Inspector of Factories, wrote: "I believe that Thackrah's early death retarded the progress of industrial medicine and surgery and the amelioration of conditions of employment for half a century. Had he lived his clinical knowledge and experience would have given prominence in legislation to the need for medical supervision in the factory and workshop by practitioners having the necessary knowledge of the home conditions of the workers and the maladies attributable to industrial life in its widest sense."

Should Guy's ever develop a department specifically concerned with industrial disease, it is to be hoped that the name of this pioneer amongst its own sons may be fitly commemorated.

Correspondence

CLUBS' UNION.

To the Editor of the GAZETTE.

SIR,—In your issue of April 28th, 1945, you published a letter over ten signatures advocating an enlargement of the Clubs' Union, to embrace all student activities, and to admit women students of medicine, dentistry, nursing, massage and radiography to its membership.

This letter was referred to a Sub-Committee of the Clubs' Union, who have now submitted a report, which is in turn being considered by the Council. As a preliminary step the Council have agreed :—

1. To grant affiliation to the Guy's Hospital Theatre Club and the Guy's Hospital Music Club.
2. To offer to the nurses, as before the War, the use of tennis-courts at Honor Oak Park at stated times, without interfering with the facilities of members, and to explore the possibility of providing pitches for field games under the same conditions. (It must be remembered that several tennis-courts have been put out of action by the war, and that the hockey pitch has been encroached upon by the building of air-raid shelters).
3. To offer facilities for fencing to the nurses.
4. To do their best to provide facilities to women medical and dental students, when these are admitted to the Schools.

Some sections of the report are more controversial, and provoked much discussion. The Council decided to refer these back to the bodies chiefly concerned.

The principal recommendation was that all student activities should be unified under one student body which would absorb the existing Clubs' Union, the Students' Club, and the Students' Union. The affairs of this body should be managed by a representative council consisting of three Staff representatives, the Warden of the College, the President of the Residents and eleven student members. This very important recommendation has been referred back to the Students' Club, and the Students' Union, and will be reconsidered at a subsequent meeting of the Clubs' Union.

For the benefit of those who were not at Guy's before the War, it is well to explain that the Clubs' Union was formed in 1891, on the recommendation of certain members of the Staff, for the very reason that is now put forward—namely, to weld together under one head the various student bodies then in existence, to simplify financial and other arrangements. It is interesting to note that it was originally intended to call it "The Union," a name more commonly used by other colleges and universities, but that as it was a union of clubs then in existence, the name "Clubs' Union" was used at the first meeting of the Council, and has continued since. It is also interesting to note that at the first meeting the Council considered an application from the St. Germain's Cricket Club for the lease of a pitch, and that this was accepted at about the third meeting.

Before the War the Clubs' Union comprised the following institutions :—Athletic Club ; Cricket Club ; Debating Society ; Rugby Football Club ; Dental Society ; Association Football Club ; *Guy's Hospital Gazette* ; Golfing Society ; Lawn Tennis Club ; Hockey Club ; Table Tennis Club ; Pavy Gymnasium ; Physical Society ; Rifle Club ; Boat Club ; Sailing Club ; Students' Club ; Swimming Club ; Ice Hockey Club. The non-affiliated institutions were the Christian Union ; the Physiological Society ; and the Musical and Operatic Society. Many of these institutions have not yet resumed functioning, but it is hoped that they will shortly do so. In all cases the running of the different clubs was left to individual committees, almost entirely composed of students, and the Council was always ready to receive recommendations and to consider them fairly, chiefly in relation to the number of members interested. The financial arrangements were run through the central office, owing to the complexity of running many small accounts, with frequent changes of secretary and treasurer. The Clubs' Union Handbook was out of print during the War, but is now in the hands of the printers.

I should like to submit that the Council did its duty in the main very well, as was testified by the great success of the majority of the institutions included under its surveillance. During the War the activities were necessarily restricted and the Council

recommended a reduction in the subscription, without any application from the members, but nevertheless attempts were made to keep most of the activities alive, in spite of war-time difficulties.

During the War the Students' Union was formed to provide facilities for cultural and other recreations of a non-athletic type. The Clubs' Union Council were interested to watch this development among the students, and as soon as it had proved itself, the Students' Union was in due course affiliated. Since that time other affiliations have been requested and granted, as noted above.

There is therefore nothing revolutionary in the suggestion that a " Union " should be formed, *for this already exists*, but it is somewhat doubtful if the Students' Club (the eldest child) and the Students' Union (amongst the youngest) will be prepared to lose their identity, as is suggested in the report of the Sub-Committee.

The Council in the past has consisted of six Staff and six Student representatives. The point at issue to-day is whether or not any great benefit would accrue from altering the balance, so that the control was mainly in the hands of students. The Council is not only the trustee for subscriptions from the many hundred students each year, but has also to exercise a watchful eye on the heritage that has been handed down, and to look forwards to the future. The Staff representatives would, no doubt, gladly be freed of their responsibilities, but have in the past provided a continuity, ably supported by the staff of the Medical School Office and Library, that could not be expected from student representatives.

This matter of representation has been referred back to the Students' Club and the Students' Union, but expressions of opinion from students, either singly or collectively, would be welcomed.

There may be some who feel that the *Gazette*, the Catering Company and the College should also come under the ægis of the altered " Union." For reasons that it would take up too much space to explain, the Clubs' Union has never been desirous of taking on these additional responsibilities, but has worked in the closest harmony with the Committees concerned. From the two former, generous grants have been made to the Clubs' Union, whilst the last has provided club-rooms at reasonable rentals, without asking the Clubs' Union to meet its deficit. It is generally agreed that the New College must have very much enlarged premises, including a hall for various entertainments.

The Clubs' Union Council is only too anxious to see evidence of re-awakened enthusiasm in all institutions, although this may mean a return to the pre-war subscription of five guineas. Two members of the Council serve on the new Co-ordinating Committee of the School Council, which has aleady done a good deal of work for the benefit of students. It is only three months since the War ended, and in view of the great damage that has been done to property, and the almost impossible task of obtaining building licences and materials, and the prohibitive cost of furniture, progress must be slow.

It would, in my humble opinion, seem the wrong moment to turn topsy-turvy the work of the past fifty years.

I am, etc.,
N. L. ECKHOFF,
Chairman, Clubs' Union Council.

Guy's Hospital, S.E.1.

" A SILENT REVOLUTION."

To the Editor of the GAZETTE.

SIR,—I do not want to start a long correspondence on the above subject, but will you allow me a few lines to thank Sister Coombe for answering my questions and for the stimulating sting in the tail of her letter.

I have no doubt that the bablies who are fortunate enough to attend the Salomon's Centre, and are consequently breast-fed, and whose mothers do not go out to work, are not liable to diarrhœa or broncho-pneumonia, but that these diseases do occur with some frequency, even in the Metropolis, is shown by the numerous papers from the London children's hospitals on their treatment.

I am, etc.,
J. VERNON BRAITHWAITE.

Crow Lees, 7, Springfield Road, Leicester.

TRUBY KING.

To the Editor of the GAZETTE.

SIR,—A letter appeared in the *Gazette* recently on the subject of Truby King from the pens of Mr. Batchelor and Mr. Laurenson. In their letter these gentlemen betray the abandonment of reason and the emotional outlook that is the mark of Truby King's followers. What has the King got to do with it all? How does Truby King's knighthood affect his wishy-washy bottle-feeding, or his archaic and unphysiological methods of weaning, or his unwholesome attitude to mother and child? How say that this man, or any man, could be "solely responsible" for the low infant mortality of New Zealand, a country obviously ideal? Why am I supposed to contemplate that "mental or physical degeneration" will overtake the New Zealanders? Why ascribe to me the statement that "much harm has been done to children" by this method, when I carefully said, "I know not how much harm"? Nor do I. I chose my words with care and with purpose; do they?

"And, finally," as they say, "although this system was rejected by Guy's this does not automatically damn it." This, at any rate, was grateful. All Guy's men will appreciate the implied compliment.

I am, et.,

H. ST. H. VERTUE.

Orpington.

"WHO WAS COUDE?"

To the Editor of the GAZETTE.

SIR,—The continued interest of the examiners in surgery in the subject of "Who was Coude?" and the lack of information on this point in the standard text-books prompts me to offer you the following brief summary of the life and work of Coude.

Coude was born in the village of Denonvilliers in 1866, the only son of simple French parents who followed the ancient art of Mogging. The young Coude was a brilliant pupil at the local school, and an essay on "Gum-Elasticity" won him a scholarship enabling him to enter a medical school in Paris. His career here was outstanding, and, despite his sound knowledge of medicine and surgery, he qualified early, held several house appointments, and was soon appointed registrar in the genito-urinary department of his hospital. While holding this appointment Coude devised the now famous single-bended catheter, though, as with most innovations, its value was not appreciated for some time.

Ultimately Coude became a genito-urinary consultant and his fame spread; indeed, he was known as "Coude the Catheter King." The zenith of his fame was reached on the morning of April 8th, 1904, when giving a demonstration of his catheter to a Surgical Convention. The patient, a case of retention due to prostatic enlargement, was prepared and Coude began to pass his catheter. He encountered difficulty, however, and was unable to enter the bladder. The atmosphere was tense, and the assembled surgeons began to register amusement at the plight of the "Catheter King" unable to pass his own instrument. Coude tried again, tried rectal guidance, the *tour de-maitre*, the catheter *fource*, all without success. Had Coude failed? Must he admit defeat? But with the brilliance so characteristic of him, Coude whipped out the catheter and, seizing it between thumbs and fingers, bent it a second time, re-introduced it and this time entered the bladder with ease. "By Coude!" exclaimed the assisting house-surgeon. "*Bicoude*," repeated the theatre sister when sterilising the instrument later, and made an entry of "Catheter, Bicoude, 1" in the theatre stock book. Thus the new catheter obtained its name.

Coude's reputation was by now thoroughly well established and his practice flourished. His preoccupation with his work led Coude to neglect his health, with the consequence that he died at the age of fifty-four of polylaminar phosphatosis, his untimely death being regarded as a great loss to surgery.

I am, etc.,

C. RETZIUS.

Guy's Hospital, S.E.1.

The Debating Society

THE Debating Society has started its activities once more, and we hope it will continue to flourish. At a meeting on November 5th, 1945, a committee was elected in accordance with the Society's constitution. At the same meeting a debate was held on the motion that "An increase in the birth-rate is to be deplored." There was some good speaking and a fair attendance.

Our most recent debate on the much vexed question of the public schools was held on November 28th. Mr. A. Collis proposed their total abolition, and Mr. R. H. N. Long defended them.

Mr. T. J. Evans was in the chair, and said how glad he was to be present at a meeting of the Debating Society once more. This debate was well attended and very lively. After considering the matter for nearly two hours the house voted against the motion.

Now that the Society has started again, we want as many as possible to support it —firstly, by attending the debates and secondly, by letting us have suggestions for motions which will be of general interest.

C. J. EARL and D. C. DEUCHAR, Hon. Secs.

Sport

Rugby

GUYS *v.* ST. MARY'S HOSPITAL.

(*At H.O.P., Wednesday, November 7th,* 1945.)

Result: Guy's, 6 points; St. Mary's Hospital, 22 points.

The crowd at H.O.P. for the visit of St. Mary's was the largest seen at the ground for a long time, and they witnessed a hard, fast and skilful game. The heavy score against Guy's gives the impression that the game was one-sided; this was not so. There were occasions when St. Mary's were compelled to bring out all their best qualities in defence, and having succeeded in stemming the Guy's attacks, they proceeded to use their skill behind the scrum in some delightful passing movements. These were carried out with such speed and subtle manœuvring that they frequently bewildered the Guy's backs.

It is hard to explain why N. M. Hall, the St. Mary's stand-off, was given so much scope; nobody was able to prevent him opening up the game, or taking a drop at goal. Our inability to subdue the opposing stand-off half has been evident in the last few matches.

Guy's made more mistakes, including the old fault of dropping passes and knocking-on; bad tackling was particularly noticeable. The three-quarters were always cramped for room and this was partly due to the slowness with which the ball came to them from the halves.

Nevertheless, there were occasions when the ball flashed along the line with accuracy and speed, and the forwards frequently carried play into St. Mary's territory with some sound rushes.

St. Mary's opened the score with a penalty goal by M. O'Connor, who also converted a try by P. R. G. Graham; this was the situation at half-time. F. Van der Westhuizen reduced the lead with a penalty goal, and Guy's had a nice three-quarter movement which ended on the wing, but St. Mary's carried play to the other end, resulting in E. K. Scott dribbling over for a try; this was followed by a try by R. W. Watson. Both were converted by M. O'Connor with brilliant kicks. Following some hard pressure in the St. Mary's "25" F. Le Clus dived over for an unconverted try, but N. M. Hall, with a dropped goal near the end, added to St. Mary's total.

Hockey

GUY'S *v.* BLACKHEATH.

(*Played at Blackheath on October 27th,* 1945.)

Result: Draw 2–2.

From the beginning of the match play was so brisk that every player was on the alert. As the ball was sent rapidly about the field, the Guy's team developed a sudden unity which had been latent in previous matches. The first goal was scored by Doyle, playing a hard shot; the second by Blackheath, followed at once by another from Doyle, the culmination of a fast movement by the inside forwards. This made the score at half-time 2–1 to Guy's. In the second half Blackheath pressed harder, and even showed their keenness by a deliberate change of position of two of their forwards in the last quarter of an hour. They scored the only goal of the second half, in spite of Prideaux, who maintained the skill and decision he has shown in innumerable matches, and Walker, whose goal-keeping developed from efficiency in the first half to brilliance in the second. Of our forwards the insides still had most of the play and, by assiduously remaining unmarked, often threatened the Blackheath goal. The game was spirited and exhilarating, a standard to remember in future matches.

Team.—F. H. Walker. B. H. Prideaux, H. W. Trusted, L. D. Carton-Kelly (captain), J. B. Harris, K. W. Bolt, C. M. M. Jenkins, I. Kelsey-Fry, A. E. Doyle, K. Y. Khong,

Other results:—

Oct. 13th.—*v.* Westminster Hosp. Won 4–1.

Oct. 20th.—*v.* King's Coll. Hosp. Won 3–0.

Association

GUY'S *v.* ST. MARY'S HOSPITAL.

(*Played at Teddington, Saturday, October 27th.*)

Result: Won 7–1.

Owing to a misunderstanding in the time of the kick-off Guy's had to start play with only nine members of the team present. This was a great handicap, but the defence was sound and the score was still 0–0 when our two remaining players arrived. This initial disorganisation of the team, however, could

not be remedied easily. The forwards tried very hard individually, but co-ordination in attack was sadly lacking. At half-time the score was 2–1 in favour of Guy's, goals having been scored by R. K. Foster and A. E. Trist.

After the interval Guy's gradually settled down and completely dominated the game. In the last twenty minutes of the game the St. Mary's defence was completely overwhelmed and five more goals were scored. Of these goals two were as near perfect as one could hope to see in amateur football. The first was a well-placed header by R. K. Foster from a high pass across the St. Mary's goal. The second was from an individual effort by W. A. Evans. By skilful dribbling Evans caused complete confusion in the St. Mary's defence and then crashed the ball into the net from 20 yards range.

Goals were scored for Guy's by:—R. K. Foster, 3; I. A. H. Munro, 2; A. E. Trist, 1; W. A. Evans, 1.

Tcam.—I. L. Busbridge; E. M. Newton, R. A. C. Dove; M. J. L. Sykes (captain), H. R. C. Riches, C. S. Matthews; I. A. H. Munro, A. E. Trist, R. K. Foster, W. A. Evans, R. Owen.

Hospital Information, etc.

Notice

HUNTERIAN LECTURES BY GUY'S MEN.

Thursday, Jan. 17th, 1946.—Professor P. W. Clarkson. "The Treatment of Face and Jaw Casualties in the British Army."

Thursday, January 31st, 1946.—Professor S. H. Wass. "The Odontomes and other Affections of the Jaws; Their Pathology, Diagnosis and Treatment."

Pass List

UNIVERSITY OF LONDON.

GENERAL SECOND EXAMINATION FOR MEDICAL DEGREES.

September, 1945.

E. Beswick	T. E. Jefferys
G. Canty	A. E. McLauchlan
J. T. Cecil	A. H. Mendoza
P. R. Chalk	N. H. Porter

Papers by Guy's Men

Yates, John. Acid fast organisms in gastric resting juice. *Brit. Med. J.*, 1945, ii, 530.

Ellis, J. S. Wounds in region of hip-joint, *Lancet*, 1945, ii, 490.

Rowlett, A. E. The Royal College of Surgeons of England and its connection with Dental Surgery. *Brit. Dent. J.*, 1945, 79, 207.

Northfield, D. W. C. An intra-oral splint for facial palsy. *Ibid.*, 213.

Neustatter, W. Lindsay. What is a "black-out": a study of fifty cases. *J. Roy. Army Med. Corps*, 1945, **85**, 139.

Bloom, H. "Cellophane" dressing for second-degree burns. *Lancet*, 1945, ii, 659.

Barnes, J. M. Traumatic œdema of the larynx. *Brit. Dent. J.*, 1945, 79, 250.

Ogilvie, W. H. Pitfalls of tropical surgery. *Lancet*, 1945, ii, 585.

Taylor, A. W. Chronic hypertrophic ileo-cœcal tuberculosis, and its relation to regional ileitis (Crohn's Disease). *Brit. J. Surg.*, 1945, **33**, 178.

Hullam, J. W. A new method of reducing dislocation of the tempero-mandibular joint. *Dent. Rec.*, 1945, **65**, 254.

Law, F. W. The ophthalmic casualty. *Clin. J.*, 1945, **74**, 211.

Campbell, Maurice. Heart block. *Ibid.*, 215.

Batchelor, J. S. Excission of the femoral head and neck in cases of ankylosis and osteo-arthritis of the hips. *Proc. Roy. Soc. Med.*, 1945, **38**, 689.

Ellis, R. W. B. Growth and health of Belgian children. *Arch. Dis. Childh.*, 1945, **20**, 97.

Rushton, M. A. A line of disturbed dentinal structure. *Brit. Dent. J.*, 1945, 79, 271.

Rowlett, A. E. Oral hygiene for partial denture wearers. *Ibid.*, 274.

Midgley, N. M., and Pringle, K. E. Eruption of upper second premolars in spite of retained second deciduous molars. *Ibid.*, 281.

Fuller, J. R. A case of localised gross caries. *Ibid.*, 285.

Ogilvie, W. H. Recent advances in treatment Surgery. *Practitioner*, 1945, **155**, 257.

Burtenshaw, J. M. L. Self disinfection of the skin: a short review and some original observations. *Brit. Med. Bull.*, 1945, **3**, 731.

Wenyon, C. M. Tropical Medicine in war and peace. *Brit. Med. J.*, 1945, ii, 774.

Change of Address

R. D. Emslie, Surg.-Lieut. (D.), R.N.V.R., H.M.S. *Excellent*, c/o G.P.O., London.

G. E. McFall, Ft.-Lieut., R.A.F., Officers' Mess, R.A.F., Biggin Hill, Kent.

G. R. M. Sichel, Captain, R.A.M.C., att. 1st S.Lan. R., M.E.F.

Dr. E. H. Rink, 7A, Worsley Road, London, N.W.3. (Tel.: Hampstead 3239.)

The Services

AWARDS.

O.B.E. (Military Division.)

In recognition of gallant and distinguished services in N.W. Europe:—

Lieut.-Col. R. Evans, R.A.M.C.

Bar to D.S.O.

Major (Temp.) B. G. A. Lilwall, D.S.O., R.A.M.C., in recognition of gallant and distinguished services in Burma.

Mentioned in Dispatches

In recognition of gallant and distinguished services in N.W. Europe:—

Major (temp.) A. K. Borland, M.B.E., R.A.M.C.

Major (acting) D. J. A. Alban-Jones, R.A.M.C.

Captain S. H. Chazen, R.A.M.C.

Births

FLETCHER.—On October 19th, 1945, to Georgina, wife of Surg.-Lieut.-Cmdr. (D.) K. E. J. Fletcher, R.N.—a daughter.

Deaths

HALE-WHITE.—On November 30th, 1945, at 24, Warnborough Road, Oxford (formerly of 38, Wimpole Street, W.1), Jane, wife of Sir William Hale-White, aged eighty-one.

WARLOW.—On November 18th, 1945, at 99, Southbourne Road, Bournemouth, after a long illness patiently borne, Frank Warlow, L.D.S., R.C.S.

EDS. {J.M.H. R.H.N.L.

A Journal of Medicine, Surgery, Dentistry and Hospital News

PUBLISHED FORTNIGHTLY

Vol. LIX No. 1498 *22nd December, 1945* *Ninepence*

PASSIM

"*Christmas comes but once a year,*
But when it comes it brings good cheer."

IF an adage has stood the test of time there is every chance that it contains a grain of truth. At present, we imagine many would deny that our deduction could be applied to this adage—or, indeed, the adage to this Christmas. Among the "many" are those whose attitude is to be condemned—the pessimists—those who individually do nothing and collectively decide that nothing can be done. With the rest—the thoughtful impartials—we can sympathise, for no one would consider that this, the first peace-time Christmas for six years, will come fully up to expectations. Unavoidable shortages in fuel and food with all the other accompaniments of the austerity *regime* will not allow it.

We recall with pleasure the war-time festivities at this season: there was the Christmas night shelter-party "Underneath the Arches," where, in a dusty subterranean atmosphere, even stronger ties were formed with our friends in the Borough. There were the revues in which production on the lavish scale of pre-war days was missing, but amply compensated for by a greater sense of intimacy and conviviality, difficult to define but nevertheless present. There were the ward-parties organised in an atmosphere of friendly rivalry. Which ward would produce the best supply of food? Whose decorations would look best? Where did X ward get their holly? There were no Nigger Minstrels, no Residents' Play, but everyone made the best of Christmas and was happy in doing so.

Moreover, there are no indications that efforts will be lacking to make this Christmas at Guy's a happy and seasonable one for everybody concerned, even though the mood of austerity is still with us. As we write rumours are already abroad of Christmas plans which, we hope, will come to fruition.

But as we here at the Hospital enjoy our Christmas session, let us not forget the host of old Guy's men who, less fortunate than ourselves, are spending yet another Christmas away from their country and their families. And, in wishing them "as happy a Christmas as possible," let us add a wish for their speedy return home. Finally, the *Gazette* would like to extend its Christmas greetings to include all its readers and to wish them also a Happy New Year.

WE were very sorry to have to announce, in the last issue of the *Gazette*, the death of Lady Hale-White. Her association with the Hospital was a long and pleasant one, and we take this opportunity of extending our sincere sympathy to her family in their bereavement.

WE welcome back Lieut.-Col. L. F. W. Salmon, R.A.M.C., M.B.E., who has returned to the Hospital and is resuming his duties in the E.N.T. Department.

A FEW more copies of "Guy's and the German War" are still available and msy be obtained from the *Gazette* Office.

Factors Modifying the Clinical Features and Course of Glomerulo-nephritis

A Clinical Lecture (abridged) delivered at Guy's Hospital on July 17th, 1945,

by A. A. OSMAN.

GENTLEMEN,—I shall assume with confidence that as students in the school of Richard Bright you are familiar with current views on the causes, and with the signs and symptoms, clinical course and prognosis of what is generally regarded as a "typical," or "average," example of glomerulo-nephritis, and shall concentrate on some less familiar aspects of the disease.

The outstanding feature of glomerulo-nephritis is the remarkable diversity of its clinical manifestations in different patients. This is true in all three stages of th disease and certainly not least in the first stage, commonly known as acute nephritis. It is necessary to remember that the text-book descriptions of this stage of the disease are mainly based upon a highly selected group, namely, those admitted to hospital on account of the conspicuousness of their symptoms and the apparent severity of the disease. It is, of course, a fallacy to regard these as "typical" or "average" examples of the disease. If a bed is available patients suffering from glomerulo-nephritis in this form are invariably and rightly admitted to hospital at once, for in no other stage is prompt and careful treatment more likely to result in arrest of the disease processes and permanent cure, or to prevent progression to the almost incurable second stage and the certainly fatal third stage.

SUB-CLINICAL NEPHRITIS.

In actual practice, however, we meet with so many examples of the disease in the first stage that differ markedly from the text-book descriptions, that we are soon compelled to revise our notions of what constitutes a "typical" or "average" case and even to doubt whether such exist. Acute nephritis, for example, very frequently occurs without giving rise either to symptoms or clinical signs of a degree sufficient to attract the attention of the patient, or even the doctor, unless the latter, being aware of the likelihood of its occurrence in the particular circumstances, as after a mild sore throat, takes special measures to detect it. In this very common form the disesase, in fact, is only detectable by laboratory methods; it is invariably missed by those who rely entirely on clinical judgment and who are so ready to deplore the increased use of laboratory methods in medicine. The first stage of glomerulo-nephritis, indeed, is often represented throughout its course by nothing more than a persistent trace of albumin in the urine. Sometimes the albuminuria is accompanied by small numbers of red blood cells and occasional casts in the centrifugalised urinary sediment, but these may only be discovered after diligent search with a microscope, or by the performance of an Addis sediment count, repeated at intervals over a prolonged period. Subclinical nephritis is much more prevalent than the text-book variety and arises, as does all glomerulo-nephritis, as a sequel to acute infections (generally streptococcal) elsewhere in the body. Not only may the patient and the doctor be unaware of disease in the kidneys, but the casual, or initiating infection—sore throat, coryza, or what not—may be so clinically inconspicuous and apparently trivial that it, too, may be forgotten or not observed. The prevalence of this form of occult nephritis almost certainly explains the frequency with which patients are seen suffering from well-marked signs and symptoms of the third stage of glomerulo-nephritis—or chronic nephritis—who apparently have never had a previous attack of acute nephritis. It would also seem to explain why so many of these patients in the third stage appear never to have passed through the second stage—sometimes called the "nephrotic stage"—for the main symptom of the latter (dropsy) is chiefly due to diminution in the protein content of the blood consequent upon continued loss of large quantities of albumin in the urine and, as we have seen, the protein loss in the urine in subclinical nephritis is throughout minimal.

We do not know why glomerulo-nephritis assumes the text-book form in some patients and the occult form in others, but there are strong reasons for believing that it is not dependent upon, nor related to, the severity of the causal infection. On the contrary, all the evidence suggests that the more apparently trivial the original

infection the more likely is the course of the disease to be progressive and unfavourable. If I may digress for a moment I would like to draw your attention to an interesting analogy in this respect with another form of kidney disease, namely, that which so often complicates toxæmia of pregnancy. Here, too, chronic progressive renal disease and persistent hypertension more often follow the clinically milder and more common pre-eclampsia than the more dramatic eclampsia. But to return to our subject. It is possible, and there is much evidence to suggest, that the prompt treatment usually accorded to patients suffering from frank glomerulo-nephritis is responsible for this difference in the prognosis in the two groups, though it is doubtful whether this is a complete explanation. The point I wish to stress, however, is that minimal signs and symptoms do not necessarily indicate a favourable outlook. It is a common experience to see patients dying from "uræmia" in the third stage of glomerulo-nephritis who "have never had an attack of acute nephritis" or who "have always had just a trace of albumin in the urine."

* * * * * * *

An important factor in determining the course and prognosis in glomerulo-nephritis is the age at which the disease is contracted. The main reason for this is that the hypertension which so often occurs at the onset is much more likely to persist in older subjects as a residual phenomenon after all other signs of the disease have disappeared. Thus, residual hypertension occurs in some 8-10 per cent. of patients who contract glomerulo-nephritis after twenty-five years of age and who do not completely recover within two to three months of the onset, but in less than 1 per cent. of patients who acquire the disease under this age. Broadly speaking, complete recovery from acute glomerulo-nephritis is common under twenty-five years of age, between twenty-five and thirty-five years of age much less common, and over thirty-five years of age comparatively rare; and this would seem to be due mainly to the relative incidence of residual hypertension in these age-periods.

Another important factor that influences particularly the symptomatology of glomerulo-nephritis is the nutritional state of the patient at the time the disease is contracted. This is especially true in connection with the prevalence and degree of the symptom—dropsy. I do not propose now to go into all the biochemical changes which are obviously of paramount importance in this connection because I did so in my last Clinical Lecture here on "Debility" a few months ago. To-day it will suffice to consider the matter from a purely clinical point of view.

I am informed by physicians long resident in the East that, in certain parts of India and China, for example, where the diet of the native consists largely of rice, acute glomerulo-nephritis is still commonly characterised by gross œdema of the large white-kidney variety. Now, œdema of this degree is nowadays only occasionally met with in this country in the first stage of glomerulo-nephritis, though formerly it was very common. Some years ago my former clinical assistants Dr. B. McArdle and Dr. C. A. Clarke and I looked up the presenting symptoms of all the patients, diagnosed as acute nephritis, admitted to this Hospital between the years 1876 to 1886 inclusive, and compared them with a similar series of patients admitted between the years 1927 to 1937 inclusive. I am quoting from memory, but, roughly speaking, in the earlier series dropsy was the presenting symptom in some 70 per cent. of the patients and hæmaturia in the remaining 30 per cent. In the later series the figures were almost exactly reversed—70 per cent. were admitted for hæmaturia and only 30 per cent. for dropsy. Both hæmaturia and dropsy were, of course, present in the majority of the patients in both groups, but the clinically predominant symptom was as stated. The enormous improvement in the nutritional state of the population as a whole that has occurred during the past half century would, in view of the experience in the East to which I have just alluded, suggest that diet plays an important part in determining the symptomatology in the early stages of glomerulo-nephritis, and that in this respect conditions in parts of the East are now similar to those that prevailed here half a century ago. Corroboration of this is found in another direction. In the columns of *The Lancet* of one hundred years ago (1844, to be exact) you will find that a long controversy was raging concerning the nature of a mysterious disorder then known as scarlatinal dropsy. It would seem that it was not then unusual for the patient, after an attack of scarlet-fever, to develop a marked and widespread œdema sometimes involving the whole body, but without albuminuria. This condition was at first thought to be distinct from post-scarlatinal nephritis in which generalised œdema was then almost the rule and which was, of course, associated with albuminuria. More prolonged and careful observation, however, revealed that albuminuria subsequently appeared in scarlatinal dropsy, and eventually it became accepted that this condition

was, in fact, post-scarlatinal nephritis in which the œdema had preceded the albuminuria. To-day we are quite familiar with this phenomenon in renal disease—occasionally in nephritis—frequently, and in more marked degree, in toxæmia of pregnancy. Nowadays, at least in this country, gross and generalised œdema is only rarely met with in post-scarlatinal nephritis—hæmaturia, often with no visible œdema, is the rule. I can recall only two instances of mild generalised œdema in post-scarlatinal nephritis when I was working on this disease in one of the London fever hospitals. Hæmaturia without clinical œdema was quite common and subclinical nephritis even more prevalent.

I have not yet observed any increase in the frequency or degree of clinical œdema in nephritis in this country as a result of war-time food restrictions, though the latter have undoubtedly made it much more difficult to treat and to control it in these patients when it does occur. Before the war one occasionally met with generalised œdema in nephritis in middle-aged men and women who had previously subjected themselves to prolonged dietetic restrictions for slimming purposes.

* * * * * * *

Another factor which modifies both the symptomatology and course of glomerulo-nephritis is climate. This acts in two ways—indirectly through its influence on the nature of the crops grown and so on the dietetic habits of the population, as in the examples we have already considered, and directly as a result of local atmospheric conditions acting on the patient. The latter effect is more noticeable in the later stages of the disease when renal function becomes grossly impaired, and is strikingly evident when a number of patients in a similar stage of the disease is being observed simultaneously.

You may recall that Dr. Johnson as a young man scoffed at the notion that the weather influenced his health or, at least, his subjective sensations of well-being, but that later in life he had to admit that it did. This is a common experience and one that many of you will share in due course. The patient suffering from the later stages of glomerulo-nephritis is in many respects also suffering from old age whatever his actual age in years. The kidneys are worn out, many of the arteries are thickened and narrowed, the blood-pressure is often high and the heart has for long been under undue strain even if it is not actually failing. In this state any patient over twenty years or so of age whose mental faculties are not also dulled will observe alterations in his subjective sensations, and often in his symptoms, corresponding with marked changes in the weather. Many, for example, will complain of an increase in such symptoms as headaches or œdema. In this connection I would like to tell you about a remarkable series of observations made in Canada some years ago. Unfortunately I have mislaid the reference and must therefore ask your indulgence and that of the author of the original paper for quoting the results from memory—I trust, correctly.

During the war of 1914-18, when glomerulo-nephritis was rife among the troops in the trenches in France, many Canadian soldiers suffering from this disease were immediately evacuated to a special hospital, or to special wards in a hospital, in Canada reserved for cases of war-nephritis. So far as I am aware this was the first occasion that anyone had had the foresight and enterprise to segregate patients suffering from Bright's disease in any considerable numbers since the Governors of this Hospital took a similar course in 1826, when, for a period of six months, they placed two whole wards at the disposal of Dr. Bright. On both occasions results of outstanding importance and significance were immediately forthcoming. At Guy's, Bright's disaease was "discovered"; in Canada, objective evidence was obtained of the direct influence of changes in the weather on the symptoms and course of glomerulo-nephritis. Briefly, the salient features of the Canadian experiment were these: it was observed that during spells of very wet weather the following changes occurred in a majority of the patients—(*a*) albuminuria increased, (*b*) the volume of urine diminished, (*c*) the blood urea increased, (*d*) the blood-pressure tended to increase, (*e*) there was a slight but definite increase of dyspnœa, (*f*) œdema increased, (*g*) headaches increased in frequency and severity. Finally, it was observed that most deaths from uræmia occurred during spells of wet weather. Unfortunately, so far as I know this work has never been followed up on any sufficient scale, with the result that we still do not know with certainty where patients suffering from nephritis should or should not reside, nor where special hospitals for their treatment should best be situated, for I assume that sooner or later their special needs will be recognised and will be catered for.

Through the courtesy of the Air Ministry I was for a time before the War supplied with daily information concerning weather conditions in London. An attempt was

made, by graphing the data supplied, to discover the relations, if any, between individual features of the weather and such clinical changes as those to which I have referred, but no conclusive results were obtained probably because the investigation was not carried on for a sufficiently long period. I still hope to have the opportunity of repeating this work. The general conclusions with regard to the clinical changes occurring in very wet weather were, however, amply confirmed and are in accordance with my own experience during the past twenty years.

These, Gentlemen, are some of the less familiar aspects of glomerulo-nephritis that I thought might be of interest to you.

Correspondence

DR. H. C. CAMERON.

To the Editor of the GAZETTE.

SIR,—I have read the letter of Mr. Laurenson and Mr. Batchelor with great interest despite some annoyance at their reference to my recent death when I had hoped to be in active work for some years yet. It is good to know that the long association between New Zealand and Guy's still continues. Years ago the name Stanley Batchelor was remembered in the Hospital long after he had left us.

If I were a New Zealander I should be filled with pride for many reasons and especially for the part played in this war by the little Island, standing in deadly danger, and uttering no word of panic or criticism, when the Mother Country could do so little to help. But I do not think that my patriotic feelings would be stirred by the scientific accuracy of Truby King. Truby King was a very vivid person, of immense enthusiasm and, as a propagandist, unequalled. But he had no pædiatric training or experience. He looked on the whole question as an intelligent layman might have done. He knew very well that propaganda among the public can never deal with a complicated theory or argument, but only with a slogan. All babies, according to him, would have health conferred on them if fed by the simple formula which he devised. All study of dietetic modifications to control the various symptoms of digestive and nutritional disturbance was to be swept away as useless. Infant feeding could no longer be a subject of interest to doctors, since it could all be learned in half-an-hour and was incapable of modification or improvement. The treatment was settled before even the baby was admitted to hospital. It became a matter of nursing routine, and there grew to be an immense number of self-confident young women, who, having mastered the handbook, all set up as authorities on the subject. The nursing of infants, so difficult and so vital for the success which the doctor aims at, can never be systematised and standardised in this way. That which is necessary for one body is prejudicial for another, and the nurse, by long experience, must learn to be all things to all babies. A routine, by which the nurse is bound, that the baby refuses means trouble. The Truby King routine and method is often successful. It succeeds well enough when success is not in question. In the 5 or 10 per cent. of cases in which difficulties arise it has nothing to offer. One might as well try to run a clinic among adults for gastro-intestinal diseases armed only with a few simple cookery recipes.

That the infantile death-rate in New Zealand is low is not due to Truby King's milk formula or to the proprietary preparations which the infant must also swallow so as to help to finance the schemes for his salvation. It is due to various causes, among them the high standard of living and of education. The low birth-rate, the absence of industrialisation, the high quality of the parental stock and the very favourable climate.

For one reason we can almost forgive Truby King for his false doctrine and psychological want of understanding of the finer points of mother-craft. He was a mighty and successful advocate of breast-feeding. I should have knighted him for that alone, although I am far from agreeing that we can argue from his knighthood that his methods were scientific or efficient. In the medical profession knighthoods descend sometimes in the oddest places. Finally, I would add that some of the strongest criticism I have heard of the system has been from men practising in New Zealand.

I am, Sir,

H. CHARLES CAMERON.

23, Devonshire Place, London, W.1.

[We thank other readers for their interesting contributions about Truby King, but regret that, owing to lack of space, we shall be unable to publish any more correspondence on this subject.]

The Consultant and Specialist

By HUGH BARBER,

Consulting Physician, Derbyshire Royal Infirmary, Medical Registrar, Guy's Hospital, 1903–1905.

"The author does not pretend to deliver thee an exact piece, his business not being ostentation but charity. . . . But it contains hints that may serve thee for texts to preach to thyself upon. . . . Accept and improve what deserves thy notice.—*Some Fruits of Solitude* (William Penn).

It was in 1862, to point some moral in political economy, that John Ruskin used the words: "Sick, we do not inquire for a physician who takes less than a guinea; caught in a shower, we do not canvass the cabmen, to find one who values his driving at less than sixpence a mile." Perhaps it did point a moral; but I have known good doctors who have responded to a call, and diagnosed correctly, acute appendicitis or scarlet fever, for a fee of considerably less than a guinea.

Now what has this to do with the consultant or specialist? Essentially nothing whatever; and yet, if one recalls the impressions of one's adolescence, perhaps most laymen did believe that a fee which included at least one golden sovereign and one silver shilling was the hall-mark of a consultant. They thought of him as a man who sat behind a handsome desk on which he wrote a prescription for some medicine more efficacious than the simple bottle wrapped up by the family doctor. It was well into the twentieth century before it was understood that the chief function of the consultant was diagnosis; and by this time special methods of investigation and the specialists were well established. One heard complaints that, whereas formerly a patient might be sent to some door with a distinguished name upon the plate, now he might be sent from door to door, all along the street, before a final opinion was given. And then came the diagnostic clinic in which all the facilities of a hospital were available, and yet there might be something less than a hospital ward achieved—something missing of that cheerful optimistic atmosphere which the hospital system and a good ward sister provide.

It took the layman some time to learn that the claim to be a genuine consultant was based on hospital experience. Sir George Savage used to say that definitions are of the devil. It is not easy to define a consultant, but in the privacy of our own profession, steadily and surely, we have tended to put foremost the question of his hospital experience, and also as to whether he chiefly gives a second opinion at the request of another doctor. It would be about 1910 that the British Medical Association made some attempt to set up a special class of consultants; but nothing came of it. In 1944, discussing the White Paper on a National Health Service, we cannot get a better definition than, "one usually accepted as a consultant in the area." Generally speaking, however, we know what we mean and by this time have with us the consultant based on a hospital, the specialist so circumstanced, the salaried specialist and those who hold a special diploma.

There is no very clear dividing line between the consultant and the specialist. The lay public have tended to adopt too readily the latter name. The best test of good work is the judgment of many individual family doctors; and, moreover, the giving of second opinions entails a close association with history and medical evidence provided by the patient's own doctor. This widens the experience of the consultant, and many specialists work along these lines; but the specialist who takes patients direct, and the salaried specialist, may be denied some of this advantage. If we are planning for the future we must remember this. At the same time, in a national scheme, we might be able to relieve the present difficult economic position of the general physician and encourage his survival.

It is rather surprising to find that Gull wrote in 1861 of the "popular prejudice in favour of specialists unfortunately too readily responded to by our profession." If he were to return, he would find that specialists had done much to add to our knowledge and been of inestimable value to many family doctors, but, of course, he touched the heart of the question by mentioning "popular prejudice." It is the family doctor who should assess the value of the specialist. In effect he gives the specialist his diploma. The royal road to consulting or specialist status has been through holding a hospital appointment. With the voluntary hospital system the number of consultants on the honorary staff has been limited by the amount of private consulting

work available in the district. To add to the number on the staff would have lowered the standard of the work. Under a national service this should not apply. We are told that many more specialists will be required, but the essential need may be expressed by saying that the personnel of the hospital staffs must be increased. We must not prepare more specialists than the hospitals can absorb. A certain proportion of those who enter the general practitioner service should have the opportunity of graduating into hospital consultants.

G. M. Trevelyan, in his *Social History of England*, wrote: "... and so the stage is set for the gradual standardization of human personality." It is a thought worthy of consideration in relation to these comparatively new special diplomas. They certainly qualify a man to become a good first assistant in a department, but they must not be allowed to limit the outlook of those who obtain them. Take, for example, a recently constituted diploma in physical medicine. I am told it will be of value for one who undertakes work in a rehabilitation centre. That may be so, and yet this knowledge is less important than is wide experience and real enthusiasm capable of infecting other people. I mean the type of man who could captain a cricket team, who could have led a revival movement or who could organise the recreation time of his patients so that they create once again their own interest in life. In fact, the sort of man who would light his pipe with a diploma.

During my time at Guy's we won the inter-hospital cricket cup three times. Someone with a diploma in batting would have made a useful man to open the innings with a more brilliant colleague; and perhaps another useful man at number six or seven. One with a diploma in bowling would be helpful to keep down the runs, while more enterprising fellows, who could mix them up a bit, took wickets at the other end. But a team composed of cricketers with diplomas would be a dull side only capable of playing for a draw. If this is nonsense—I only wish to say that, when I was an undergraduate, many of us thought the study of medicine was more fun than playing cricket, but that sometimes an examination cramped the style of our education.

In 1902 a friend of mine told Mr. Lane (later Sir William Arbuthnot) that he was entering for the final examination of the Fellowship of the College of Surgeons, to which that distinguished and original surgeon responded: "Don't forget that it is an examination in old wives' tales." Chesterton says: "Woe unto the flippant because they shall receive flippancy." But we knew that genius may touch one aspect of a subject in a manner quite unsuitable for lesser minds. To us, who understood, it was just another example of Lane's gift of showing up some aspect of a subject which our duller brains might miss. The old-standing diplomas, however, which have stood the test of time and which cover a wide field of professional activity, are in a different category from those more recently established in some narrower field.

A specialty carried out by salaried officers may reach a very high standard. but if it should be low the profession locally have little opportunity of voicing their criticism. Of tuberculosis I can write historically. It made a bad beginning under the State. Osler, who had been a pioneer in the tuberculosis campaign, had written in 1911 that he "dreaded the growth of a group of men whose whole life and experience was in tuberculosis." His advice that the dispensaries should be associated with the general hospitals was not followed. The medical officer of health in the county where I practised told the profession and his lay committees that a certain physician was "the greatest benefactor of mankind since the days of Lister, because he had proved that the working-man could be cured of phthisis by means of tuberculin injections whilst he remained at work." That is a piece of history worth remembering; because the idea was so tempting of belief for an administrative officer. The family doctor and the hospital consultant know that a little wishful thinking may be beneficial, but they are conversant with the limitations of their calling. No clinicians of experience could have made a start so disastrous as was made to the tuberculosis scheme. It was an example of specialisation divorced from any claim to be a second opinion, and I knew good family doctors who refused to notify their patients. When a salaried specialist is appointed, the family doctors in that area should have considerable responsibility in choosing him.

The venereal disease clinics have in most areas been attached to general hospitals. This only came about in the first instance so that the patients should have privacy. But the officer in charge has derived benefit from being in touch with colleagues working in other branches.

In a State service it is inevitable that there should be some degree of uniformity, but this may be stultifying, and there is similar danger in relation to special diplomas.

In the first World War it was my good fortune to act as one of the pathologists to the most famous hospital for venereal diseases in France. I arrived at a time when the master mind had left for a post at home. The hospital was in first-class running order, based on his experience and technique; but it was all according to authority. For example, he had laid down the wise law that no man must be submitted to an anti-syphilitic course of treatment until the diagnosis had been established. And, of course, in the primary and secondary stages this would signify the finding of a spirochaete and not just a blood test. There could be no criticism of this. He had taught that no primary lesion must be treated by an antiseptic ointment, and no man must have an arsenical injection until the organism had been demonstrated—it was more or less an Army order—because it would rob the pathologist of his opportunity of proof.

When I came on the scene this was an accepted principle, and if by chance a patient came up to the laboratory for investigation of a primary lesion to which some antiseptic had been applied, my senior colleague (my junior in years) would dismiss the man with a note to the effect that to look for the spirochaete was a waste of time. This was bowing to authority, and perhaps showing self-importance at the same time. Eventually I obtained leave to investigate these patients, with the result that a little perseverance always led to the finding of the organism. When I sought out some men who had received one injection of arsenobenzol and demonstrated the spirochaete from them, I was treated as a heretic. I had impugned the infallibility of a man of great experience. But I agreed entirely with his rules; it was the rigid interpretation by his little disciples, who thought themselves so big, which I upset. I should have got a bad mark if I had been staying in the service.

Of course a man who poses as a heretic can be a nuisance. Samuel Johnson said: "When I was a boy I used always to choose the 'wrong side' of a debate, because most ingenious things, that is to say, most new things, could be said upon it." If the things are capable of proof, however, let us settle the question.

The classic example of orthodox power being exercised over a heretic came in 1559, when John Geynes was cited before the College of Physicians for impugning the infallibility of Galen. Next year, when he acknowledged his error and humbly signed his recantation, he was received into the College. If he had not recanted, it is clear the College would have been in the wrong; but the event suggests that his originality may have been only a pose, something of the young Johnsonian type, because this reclaimed heretic held posts of honour in the College soon afterwards. Perhaps it was in the best interests of the community that the profession should be orthodox. And possibly John Geynes may have been wise in his generation. There is little gained by being burned at the stake for a trifle. By all means let us be orthodox; but the trouble is that history does not suggest there is hostility, if the original ideas are false; but it makes a considerable upset, if they are true. What was in Sydenham's mind when he wrote of those who might deem themselves injured when others proclaim new facts of which they themselves had no previous knowledge? After studying fevers for fifteen years he could write: "Better would it have been for my present fame to have continued some vain and useless speculation."

Of course, some of our forefathers put forth their views in a rather tactless form. There was a certain Samuel Haworth, Fellow of the College of Physicians, who published in 1682, "The true method of curing consumption; wherein the vulgar method is discovered to be useless and pernicious." He is stated to have gained some notoriety as a curer of consumption by a special method of his own.

No doubt Locke's dictum that "truth scarce ever carried it by vote anywhere at its first appearance" is both true and all for the best; because the opposition is a necessary check, and the truth in time will prevail. Osler says: "... in science credit goes to the man who convinces the world, not to the man to whom the idea first occurred." The credit is due and the actual prophet, who began it, must not expect much sympathy from those near at hand. Some of Addison's original papers on disease of the suprarenals were refused publication in the transactions of a society of which he had been president; but he was not without honour in France, where Trousseau gave the name "Addison's Disease." *The Autocrat of the Breakfast Table* says: "Every real thought on every real subject knocks the wind out of somebody or another." I suppose the full blast of it is tempered when it goes across the seas.

It is true that one who specialises in a particular disease will know most about some aspects of the problem. Particularly so if there is some technical treatment to perfect. Hilton Fagge is described as having no predilection for any one class of

disease, which may lead a man on " to some inferior work requiring little more than mechanical nicety for its aim." There are times when mechanical nicety is most important, but the limitations must be recognised. It may be attractive to take up a special branch, but I have been interested to notice that a young enthusiast may find that in time his interest flags. He may wish that his work was of a more general nature. The economic struggle may tempt a young man into a narrow field with a diploma and a salary, but if the whole economic situation is under review it should be possible to lessen this temptation by offering a life of wider scope.

We have nearly stamped out typhoid fever, but this did not throw any specialists out of work. It will be a long and arduous task to control tuberculosis, and we must remember that the general physician and the family doctor are likely to have better facilities for thinking out the problem than those who are associated with technical treatment. We sometimes hear of obsolete operations. The specialist in the treatment of one or two diseases must look forward to the day when he himself will be obsolete.

The narrow field of specialism may not be the best in which to try out a new remedy. There is no doubt that its worth is proved most quickly and surely in a voluntary hospital, with colleagues of equal status. The enthusiast who begins the trial under the eyes of these colleagues is criticised at a table of half-a-dozen or more residents. The truth is soon arrived at ; no Hospital Board worth its salt will criticise the expense ; there need be no window-dressing if the treatment is discarded ; and if it is successful the colleagues are using it almost before the first to introduce it is prepared.

There is little to criticise in those specialties which have stood the test of time. The criticism comes when a new instrument of precision, or some special technique in diagnosis, takes one particular organ out of the general wards. I heard the late Sir William Wheeler give one of his last addresses, in which he suggested that we might have a specialist trained in the use of all " scopes." The time and dexterity required to perfect the handling of some new instrument may confuse a busy man ; but it is not good practice to contract the field of the clinician by reason of this. I heard a senior physician say that a certain instrument was regarded as sacred ; to be touched by the elect only. This will pass. When a student is required to show some knowledge of it in his examinations, he will claim to use it, if later he comes upon the staff of a hospital.

Sir James Mackenzie, in his later years, preached the doctrine of the Simplification of Medicine. After a period of research work in some special branch this should be possible—rather like the alpine climber's slogan of progress, from an inaccessible peak to a difficult climb, to an easy day for a lady. We should encourage the evolution of medicine along these lines. There is a saying that you cannot put back the clock; but we do put it back each autumn. All honour is due to those who have worked up a specialty, but they must not work it to death or create some vested interest. A time may come when the true vitality of the subject depends upon its return to the general wards.

Youth and age have each their point of view ,but the Prime Minister said to the College of Physicians : " The longer you can look back the further you can see forward." The wisdom of experience is not reaction. Special departments and specialist workers have added much to medical knowledge, but we must give consideration to the same thought in a similar groove of the minds of Sir William Withey Gull, Dr. Charles Hilton Fagge, Sir William Osler, Sir James Mackenzie, Sir William Wheeler, and—well, I must not place myself in the same predicament as the gentleman who said that a number of distinguished people had died recently and that he did not feel very well himself. (Barrie, in one of his personal letters, says : " There ought to be an exclamatiom mark here ; but it is against my principles.")

The voice of experience is not raised against specialisation itself, but rather in fear lest we should lose the general physician or surgeon with a wide outlook ; whom Sir William Osler described as the " leaven of the whole profession."

These rather disjointed notes contain a little history, a little personal bias, some hints (not meant to be presumptuous) with regard to the spirit of planning. May I conclude with the words of William Penn : " Accept and improve what deserves thy notice ; the rest excuse and place to account of goodwill to thee."

A friend of mine, who describes himself as a Specialist on the Constitution, has given me :—

THE FABLE OF THE BELLY AND THE MEMBERS UP TO DATE.

"What's all this commotion?" said the Constitution.

"Well," said the Heart, "my cardiologist tells me that I make the effort when we climb the stairs."

"Yes," said the Legs, "but our orthopædic surgeon says that we are shaped so nicely to carry all the weight."

"Perhaps you are not aware," said the Thyroid Gland, "that our endocrinologist believes that I and my relatives are responsible for the amount you have to carry."

"Now that my radiologist," said the Stomach, "can show my outline like a tea-tray in the sky, you must not call me Belly any more."

"Quite!" said the Colon. "But I would ask you to remember what distinguished surgeons——"

"We know," said the Constitution, "they would not keep you in your place. You should be neither seen nor heard."

"Do you suppose," said the Pancreas to the Liver, "that these people ever heard of a metabolist?"

"I doubt it," said the Liver, "but I am not impressed with his efficiency."

"Our ancestors," said the Blood Corpuscles, "made their home in the web-foot of a frog; but now our hæmatologist seeks us in the breast-bone when we are in the tadpole stage."

"Yes," said the Constitution, "he can tell you, as a shepherd tells his sheep, but he cannot tell me why your tadploes go astray."

"My psychiatrist," said the Mind, "could keep all the rest of you in order."

"So they tell me," said the Constitution. "But, my children, this must cease or it will end in tears. To-morrow you shall see my family doctor."

"What!" cried all the Organs together. "See just a doctor with a stethoscope in these enlightened days."

"A doctor with his senses," said the Constitution; "who else may use the words h pull together'? I am afraid that the general physician to whom my doctor refers is more difficult problems may soon be retiring from practice."

Reviews

A Manual of Opthalmology for Medical Officers. By Lieut.-Col. B. W. RYCROFT, M.D., D.O.M.S., F.R.C.S.(Eng.), R.A.M.C. Published by Hamish Hamilton Medical Books, 90, Great Russell Street, London, W.C.

THE scope of this small book is well described by its title; it is an introduction to the essentials of opthalmology and a description of the method of its practice in the Services. All the commoner opthalmic diseases are fully dealt with as regards diagnosis and treatment, though traumatic affections and those diseases peculiar to the limited age-groups dealt with under Service conditions are not unnaturally especially emphasised.

The print is clear though the paper is manifestly "wartime," and perhaps one's major quarrel is with the illustrations which show none of the accuracy of draughtsmanship and colour usually associated with opthalmology text-books. This I consider to be a mistake, since such illustrations would go far towards replacing the paucity of experience of the reader. Two minor criticisms might also be made in that, firstly, Appendix 2, "A Nomenclature of the Diseases of the Eye" would have been more useful had it been a definition of opthalmic terms; and, secondly, there appears a conspicuous lapse on the part of the author in describing the maintenance of a sulphonamide course as being "two tablets given thrice daily."

Nevertheless, Lieut-Col. Rycroft tactfully realises that opthalmology is not uncommonly the Achilles heel of the newly qualified, and one is impressed throughout with the simplification, yet lack of over-simplification, which makes this handbook intelligible and readable. D. O'K.

Diseases of the Nervous System. By F. M. R. WALSHE, O.B.E., M.D., D.Sc., F.R.C.P.(Lond.), Hon. D.Sc. (Nat. Univ., Ireland). Fourth Edition. Published by E. and S. Livingstone, Ltd. *Price* 15*s*.

A NEW edition of this text-book has been published because in the last two years there have been changes in the ideas of the majority of neurologists—for example, the ideas about peripheral nerve injuries. New, partially tried methods of treatment are not described in this text-book, whose function is to present neurology practically and comprehensibly. There are fewer words than there are in the section on neurology in Price's "Textbook of Medicine," there are diagrams and X-ray photographs as well as words and the arrangement of matter is encouraging, so that the reader is gently introduced to the labyrinthine complexity of nervous disease.

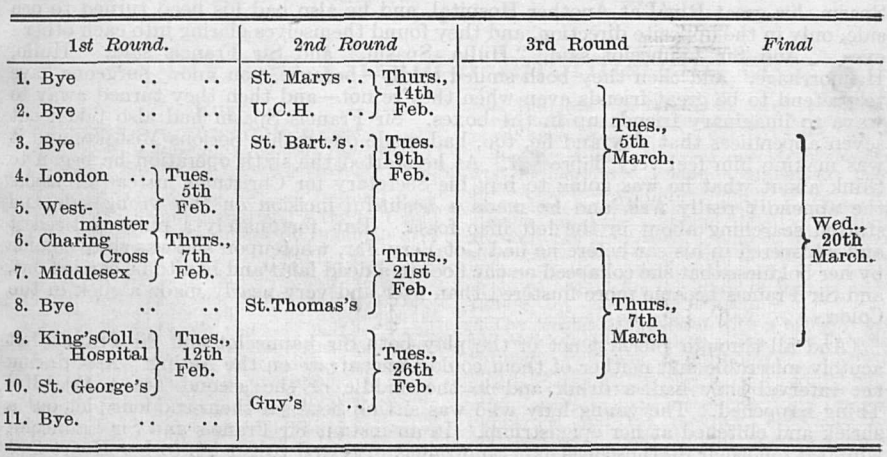
There is no room for descriptions of experimental work, but the interest of Dr. Walshe in the basis of modern developments was clear in his recent lecture on "Anterior Poliomyelitis" to the Royal Society of Arts. He spoke then of clinical work in Sweden and in the United States of America and of laboratory research.

The great service of Dr. Walshe to his readers is his appreciation that the writing of a book is a work done by more than the haphazard commission of facts and theories to paper. He has arranged his chapters and paragraphs lucidly, though his style is, unfortunately, rough. Here and there he has resorted to clichés hallowed by thousands of medical authors, such as the expressions "on the whole, perhaps" and "factor in causation." At their best such phrases are a pathetic attempt to ornament simple truth, and at the worst they are a poor camouflage for muddled thought.

Not infrequently the reader is not unirritated by his text-books, and thanks are due to Dr. Walshe for being kinder than most authors. H. W. T.

United Hospitals' Rugby Football Club

DRAW FOR HOSPITAL CUP COMPETITION, 1946.



The Hospital Cup Competition is being renewed this season. It was last won by St. Mary's Hospital in 1939.

Guy's have won the Cup 26 times; St. Thomas's, 11 times; St. Mary's, 7; London, 6 St. Bartholomew's, 5; St. George's, 3; and Middlesex, 1. Guy's were last successful in 1933, since when St. Mary's have won six times running.

The Hospital Seven-a-Side Competition is on Saturday, April 13th, 1946.

Mistletoe: or How Dr. Myocardium Came to Specialise in Hearts

By HAROLD NEATE.

(*With apologies to* Joyce Dennys.)

IT all started during Christmas week, not many years ago, when one of the Nurses tied a Little Piece of Mistletoe to the lamp in the Surgeons' dressing-room. On that day Sir Launcelot Hæmorrhage had performed seven operations for appendicitis. Actually he had only done six operations all by himself because, on the last occasion, the Theatre Sister sent him off to change his gloves when he inadvertently put up his hand to stifle a Cough, and his Senior Dresser had to finish off putting the stitches in. And so Sir Launcelot was feeling rather upset when he returned to the dressing-room to take off his rubber boots, and he plonked himself down in a chair and lighted a cigarette. And he blew a big smoke ring and watched it float upwards until it surrounded the Little Piece of Mistletoe and then he had an Idea. And he got up and went to the door and looked down the passage, where a nurse was standing—idly wondering whether $\frac{20}{24}$ on a bougie meant inches or feet. And he called out: "Nurse," quite softly, and she dropped the bougie and ran towards him. You will not be surprised to hear that it was the same nurse who had fixed that Little Piece of Mistletoe, and she had had a violent Crush on Sir Launcelot for several weeks and was getting quite thin over it. And Sir Launcelot led her by the arm right under the lamp and, drawing her to him, he kissed her very tenderly indeed. At that moment the Theatre Sister appeared, and stood by the door speechless with horror. And all that she eventually managed to say was "Sir LAUNCELOT," which she said pretty well, and then she went away again.

So when Sir Launcelot left the hospital that night he thought he might feel better if he went to see a show before going home, and he bought a ticket in the third row of the stalls at a large West End theatre. And as he sat down he heard some people murmur in the row behind, "I wonder who THAT distinguished man is," and it pleased him very much and he turned his head to one side so that they could see his Profile.

And then he had a Nasty Shock because in the next seat but one was Sir Francis Spasm, his great Rival at Another Hospital, and he also had his head turned to one side, only in the opposite direction, and they found themselves glaring into each other's eyes. And Sir Launcelot said, "Hullo, Spasm," and Sir Francis said, "Hullo, Hæmorrhage," and then they both smiled coldly—because, you know, surgeons have to pretend to be great friends even when they're not—and then they turned away to wave to imaginary friends up in the boxes. Sir Francis Spasm had also taken out seven appendices that day and he, too, had made one rather Serious Mistake, and it was making him feel very depressed. As he started the sixth operation he began to think about what he was going to buy his Secretary for Christmas instead of where the appendix really was, and he made a beautiful incision on the wrong side and started searching about in the left iliac fossa. But fortunately a nurse noticed it and whispered in his ear before he had Got Very Far, whereupon she was so overcome by her boldness that she collapsed on the floor in a dead faint and had to be carried out, and Sir Francis became more flustered than ever and very nearly made a nick in the Colon.

And all through the first act of the play both Sir Launcelot and Sir Francis felt acutely miserable and neither of them could Concentrate on the Acting. And during the interval they had a drink and in the middle of the second act a Dreadful Thing happened. The young lady who was sitting between them suddenly let out a shriek and clutched at her epigastrium. In an instant Sir Francis and Sir Launcelot whipped out their Stethoscopes but Sir Francis managed to get his to her Heart first because he was sitting on her left, only he couldn't hear very much because of the noise which was going on. And after some confusion they succeeded in getting her on to a sofa in the Foyer. And while Sir Francis and Sir Launcelot were haggling over whose patient she ought to be, young Dr. Myocardium, a struggling G.P. from the Suburbs, who was having an evening out in the Upper Circle, rushed down, after hearing the shriek, to see whether a doctor was needed. And when he had examined the young lady very carefully he came to the conclusion that she was suffering from

Hysteria, although he was prepared to admit the Possibility of Acute Dyspepsia, but when he found out that she had had oysters and champagne for dinner (and champagne of a bad vintage at that) he decided that the Hysteria was very likely only an Aggravating Cause. And he mixed her a strong dose of Sodium Bicarbonate—for Dr. Myocardium, being a Thorough Man, always carried his Little Black Bag with him—and after that she improved in a really remarkable way.

Meanwhile Sir Francis and Sir Launcelot had both hurried off to telephone for an ambulance and to tell their Hospitals to Prepare the Theatre at once for an Acute Appendicitis.

But Dr. Myocardium's skill had created quite a stir in the Foyer and, as soon as the young lady recovered, they walked off together, hand in hand, and went and had a drink. It was all in the papers the next morning, and Dr. Myocardium became famous overnight, and very soon he and the young lady were married and there was a huge reception at the Dorchester. And one day, when his wife told him what a nice surname she thought he had, Dr. Myocardium repeated it to himself once or twice and knew immediately, for he was no fool, that his future was assured. And it was not long after he had begun to Specialise in Hearts that he was able to sell his Practice in the Suburbs and settle down in Harley Street with a real Constable landscape in the waiting-room and a twelve-litre Lagonda in the garage.

As for Sir Launcelot Hæmorrhage and Sir Francis Spasm, they were furious, of course, when they returned from the telephone to find their patient had flown, but, fortunately, two Acute Appendices *did* come into their respective Hospitals that night, and so the instruments which had been sterilised on their instructions weren't Wasted after all. And after that they both felt much better about the Whole Thing and Sir Launcelot even went so far as to have an appendix, entangled in a sprig of mistletoe, on his Christmas Cards as a crest. And he sent one to the Theatre Sister at his Hospital for a joke, but she didn't think it was in the least bit funny.

And some years later, at a big cocktail-party in Wimpole Street, when Dr. Myocardium was almost, but not quite, as famous as Sir Francis and Sir Launcelot, he drew them aside into a corner and told them the Whole Story, and the two great surgeons became quite friendly and they all three had a good laugh over it. And Sir Launcelot told Dr. Myocardium that if it hadn't been for that Little Piece of Mistletoe he would never have gone to the theatre that night, and Sir Francis would have attended to the young lady who was now Dr. Myocardium's wife. And Dr. Myocardium said jokingly that Sir Francis would have removed his wife's appendix for certain, and then they all had another laugh—only, this time, Sir Francis didn't laugh quite so heartily as the other two.

Sport and Hospital Information, etc.

Rugby

GUY'S *v.* ROSSLYN PARK.

(*At H.O.P., Saturday, November 17th*, 1945.)

Result: Guy's, 12 points; Rosslyn Park, 9 points.

This heartening victory over Rosslyn Park by 1 goal, 1 dropped goal and a try to 1 goal and a dropped goal should do much to give the team confidence.

The return of T. L. T. Lewis to full-back, and R. D. Willcock to scrum-half, following his injury in the trials, contributed largely to the success of the side. The excellence of Willcock brought out the best in Le Clus at stand-off, who proved his fine attacking qualities by giving his backs numerous chances, and only some determined tackling by the Park saved them from a heavier defeat.

Jones left the field through injury ten minutes after the start and the re-arranged line carried out some dazzling movements, and credit must be given to Owen for a sound display at left centre and to Hatton, his partner, withdrawn from the pack. The seven forwards held the Park magnificently and, against such an expert hooker as J. Tyler, the frequency with which J. Keeling got the ball was amazing. Somebody in our pack must have been shoving very hard. There was also a big improvement in the line-outs, but there is still a tendency to hold the ball too long by trying to force a passage through the opposing forwards. These tactics never succeeded.

Rosslyn Park, who were one short for the first five minutes, scored a try during that period through L. H. Garrett, which I. P. D. Kempton converted; but N. K. Macrae-Gibson, swerving outside three opponents, reduced the lead with a perfect try from a movement started by Van der Westhuizen. Things looked black when P. F. Cooper dropped a goal for the Park to lead at half-time 9–3.

The second half opened with a brilliant try by Van der Westhuizen, who broke clean through, following a "dummy," to touch down by the post, and T. L. T. Lewis converted. Guy's defensive touch-kicking was most accurate whenever the Park looked dangerous and the tackling, especially by Macrae-Gibson, was sot sure that the Park had few chances to add to their score.

Towards the end Guy's made many attacks and deserved to score, when Van der Westhuizen swerved to the wing and gave an inside pass to Macrae-Gibson, who was tackled before taking the ball, but Lewis just failed with the penalty kick. However, Van der Westhuizen won the game with a dropped goal, following severe pressure in the Park's "25," giving Guy's a well-deserved victory.

GUY'S *v.* DEVONPORT SERVICES.

(*At Plymouth, Saturday, November 24th*, 1945.)

Result: Guy's, 15 points; Devonport Services, 6 points.

The team included D. Le Clus at full back, B. M. Gray on the left wing, and T. K. Walker in the pack, these slections being made to replace T. L. T. Lewis, D. G. Jones and A. Batty Shaw, who were unable to travel.

A few promising three-quarter movements opened the game and after about ten minutes F. Le Clus cut through neatly from a set scrum and, drawing the full-back, sent Van der Westhuizen away to score a try under the posts, which was converted. The game progressed evenly for a while and then Van der Westhuizen broke away to score a similar try —again adding the major points himself. Half-time saw Guy's with a ten-point lead.

The second half began rather indeterminately and then lapsed into that terrible mid-second-half fifteen minutes which has lost Guy's many a match. During this period the team played without punch, and Devonport scored twice—firstly, from a loose skirmish near our line and secondly, from a line-out about the 25 yard line—several loose forwards breaking and rushing. Both tries were unconverted. During this period the backs kept up a pretty staunch defence against several severe onslaughts from the opposition. Near the end of the game De Villiers gathered a fumbled pass by our opponents and ran half the length of the field to touch down, a little the worse for wear, under the posts. Van der Westhuizen again converted.

The forwards played a good game against a tough pack and certainly got their fair share of the ball. D. Le Clus, at full back, played a masterly game with some very fine kicking.

GUY'S *v.* COVENTRY.

(*At H.O.P., Saturday, December 1st*, 1945.)

Result: Guy's, 8 points; Coventry, 21 points.

A large crowd saw the fine Coventry team triumph over the Hospital by 2 goals, 2 dropped goals and a penalty goal to 1 goal and a penalty goal.

In meeting such a successful side as Coventry one cannot resist drawing comparisons, and the reasons for their long sequence of victories are not far to seek. Their team-work was magnificent; every man seemed to have a special job of work and their tackling, combined with sound backing up and quick heeling, enabled their backs to have almost a monotonous monopoly of the ball. Moreover, they introduced into their play a variation in tactics which made gaps in our defence and particularly noticeable was the manner in which the scrum-half came into nearly every movement by the backs.

Individually, the Hospital players did well but in contrast to Coventry their team work left much to be desired and, opposed as they were to a brilliant pack, they did not infuse that extra bit of vigour into their play so essential to success.

Guy's may congratulate themselves on having their line crossed only twice; high tacking was the cause of Preece breaking through on both occasions. Another reason why Coventry looked so much better in attack was that they had the ball from most of the set scrums, and, although the placing of De Villiers with Hilliam in the middle of the line-out brought some improvement, there were other Guy's forwards not marking a man at all.

Coventry gave us an early shock and an example of their tactics when Kenyon dropped a goal after four minutes' play. Some excellent touch-kicking by Lewis and Le Clus helped Guy's to make ground, and one movement in the first half when the ball went from wing to wing and back again thoroughly deserved a score. However, Van der Westhuizen very smartly sold a dummy and, breaking through, cross-kicked, and Hatton, fielding cleanly, dashed over near the posts for Lewis to convert. Guy's really looked like making it a close game, but Preece came on the scene with a dropped goal which was followed by Coventry's first try: a cut through across field by Preece, who sent Sparkes over for a try, which Wright converted.

Although Guy's defended for most of the second half Coventry found some difficulty in turning their movements to account owing to some excellent tackling by Owen and Macrae-Gibson. Late in the second half Preece pounced on a loose ball to cross the line, and Wright again converted. Guy's staged a grand rally in which Willcock was conspicuous; first De Villiers was pulled down near the line, and then Hatton, but Coventry repelled this attack and gained a penalty through Lewis not playing the ball in an exciting *melee*, Wright having no difficulty in kicking his third goal.

This Guy's side is a good one. Errors are committed in the general run of play which can be eliminated by better understanding and they are slow in seizing on their opponents' mistakes, however small in number.

Hockey

GRAVESEND *v.* GUY'S.

(*At H.O.P., Saturday, November 17th, 1945.*)

At the start of the match our opponents quickly scored goals by their alertness; then we settled down to hockey as steady as any we have played. The forwards were stimulated by Burt's return, and they had by half-time made the score 3 all. In the second half the average play remained at a high standard, though there were some moments when the defence crumpled, and others when our passing was, unfortunately, directed to our opponents rather than to one of our own men. Result: 4–4.

Team.—F. H. Walker, H. W. Trusted, J. Swann, L. D. Carton-Kelly (captain), J. B. Harris, K. W. Bolt, C. M. M. Jenkins, K. Y. Khong, J. R. Burt, A. E. Doyle, B. Wotton.

Change of Address

R. R. Burn, Capt., R.A.M.C., 53rd Field Regt., R.A., Bardney Camp, nr. Lincoln.

John Gordon, Ft.-Lt., R.A.F., Kerry Cottage, Oaklands Avenue, Esher, Surrey.

J. R. Rickett, M.R.C.S., L.R.C.P., 21, East Street, Havant, Hants.

L. F. W. Salmon, M.B.E., M.B., B.S., 48, Lynwood Grove, Orpington, Kent.

J. A. R. Smit, Sqn-Ldr., R.A.F., Vergezicht, Kloof Street, Cape Town, South Africa.

Marriages

THOMAS—DOOGAN.—On December 15th, 1945, at Dunsfold Parish Church, Gerald T. Thomas, Ft.-Lt., R.A.F., to Anne Doogan, of Tully House, co. Monaghan.

PLOWMAN—BURT. Quietly on November 30th, 1945, at Christ Church, Enfield, R. D. Plowman, Surg.-Lieut., R.N.V.R., to P. L. Burt, V.A.D.

Births

MORSMAN.—On November 20th, 1945, at Guy's Hospital, to Audrey ("Pip") née Phillips, wife of Raymond Morsman—a son (John Murray).

Deaths

CLEWER.—On 11th December, 1945, in London, Donald Clewer, Major-General A.D. Corps., C.B., Col.-Commandant, The Army Dental Corps. Aged 53 years.

EDS. {J.M.H. R.H.N.L.

THE WILLS LIBRARY,
GUY'S HOSPITAL,
LONDON, S.E.1.